Manitoba Family Services and Housing

Response and Action Plan

to the Office of the Children's Advocate

Shelter System Review Report

Review into the Operation of the Winnipeg Child and Family Services Emergency Assessment Placement Department Shelter System

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Manitoba Family Services and Housing

Response and Action Plan to the **Shelter System Review Report**

1. OVERVIEW

The child and family services system in Manitoba is undergoing a historic restructuring. Through the Aboriginal Justice Inquiry-Child Welfare Initiative (AJI-CWI), Aboriginal children and families in Manitoba will receive culturally appropriate services in a new system governed and operated by Aboriginal persons, in partnership with government. The Children's Advocate report notes: "it has been demonstrated through numerous studies that the child and family services system has not well served Aboriginal children, youth and their families. This is a fundamental reason for the AJI-CWI."

The recently proclaimed *Child and Family Services Authorities Act* is a cornerstone of this initiative. This legislation, proclaimed in November 2003, established four new child and family services authorities. Three are Aboriginal Child and Family Services Authorities and the fourth is the General Authority (for all other families). Each is responsible for serving families from their communities regardless of where they live in Manitoba. As part of these structural changes, resources are being transferred from the existing service delivery system to the control of the newly created authorities.

Winnipeg Child and Family Services Branch currently provides a full range of child and family services in Winnipeg. When the Advocate's review was launched, Winnipeg Child and Family Services was under the jurisdiction of a board of directors, the majority appointed by government. Since April 1, 2003, Winnipeg Child and Family Services Branch has been operated directly by government as a branch of Manitoba Family Services and Housing.

Winnipeg Child and Family Services Branch provides out-of-home placements for at-risk children who require short-term care, on an emergency basis. These placements are referred to as the Short-Term Emergency Placement (S.T.E.P.) System. Shelters are one type of placement resource used for this kind of short-term, emergency care. Shelters are group-care residences that are staffed in shifts, that range in size from two to six beds. Every effort is made to provide a home-like environment in the shelter system. Children stay in the shelters while professional social work staff develop plans to return them home or arrange for a more permanent placement.

Planning continues to transfer much of the child and family services system in Winnipeg to the control of the Aboriginal authorities. This is following a similar devolution process occurring in other regions of the Province and will include transferring responsibility for delivering emergency, short-term placement resources for children in temporary care.

2. BACKGROUND

In December 2002, the then Minister of Family Services and Housing requested that the Office of the Children's Advocate conduct an operational review of the emergency shelter system within Winnipeg Child and Family Services. The review arose mainly due to concerns about the quality of care being provided in those emergency shelters. As noted in the Advocate's report, Prairie Research Associates identified concerns about the short-term placement system as early as 1997 when the shelter system was developing. A rapid growth in the number of shelter facilities from 1998 to 2000, due primarily to a shortage of emergency foster homes, also raised some quality of care concerns.

Since 2001, Winnipeg Child and Family Services has developed alternate placement resources to relieve some of the pressure being exerted on the shelter system. This was part of a coordinated strategy to ensure the shelter system was able to effectively fulfil its mandate of providing temporary, not long-term, care for children.

A three-person team from the Office of the Children's Advocate completed the operational review. The team conducted extensive research including a comprehensive analysis of statistical data on admissions over a five-year period, a literature review, visits to over 40 different shelter facilities and interviews with staff of the shelter system, management, union representatives and stakeholders. Most importantly, the research team also interviewed children who are, or have been, placed in the shelter system. The comments and experiences of these children provide the most valuable insights into the quality of care being provided. This extensive research, utilizing both statistical and experiential information, provides a thorough assessment of the shelter system. The final report was provided to the Minister of Family Services and Housing in April 2004.

After receiving the final report, Manitoba Family Services and Housing immediately developed an action plan to respond to the Advocate's recommendations. The purpose of this paper is to describe the action plan.

3. SUMMARY OF KEY FINDINGS OF THE SHELTER SYSTEM REVIEW REPORT

The Advocate has produced a final report that is quite comprehensive and has an extensive discussion of the key issues and challenges facing the emergency care system. The purpose of this section is to provide a summary of the report's main themes and connect key findings with Manitoba Family Services and Housing's action plan. This is not intended to be an exhaustive overview of the Advocate's findings or recommendations. The far-reaching nature of the Advocate's assessment and recommendations can only be fully understood by reading the entire report.

(a) Theme – Quality of Care

The primary reason for the review was concern about quality of care in the shelter system. Overall, the report indicates that the basic care needs of children are being met. The Advocate writes "children and youth reported that routines were established in the shelters, they received adequate nourishment and were involved in daily activities." Many children interviewed report having a positive relationship with their social worker.

The physical environment of most shelters is judged to be adequate although the Advocate does express concern about facilities located in unsafe neighbourhoods. The staff of the shelter system are seen to be qualified and committed to their jobs but may not have adequate training to meet the complex needs of some children in care.

The report does raise concerns about the extent to which the shelters are able to offer programming, recreational opportunities and ensure children are attending school. The report suggests that the staffing model may not be the most desirable given the potential impacts on quality of care. Further, based largely on a thorough assessment of the care provided in Winnipeg's shelters and approaches used in other jurisdictions, the Advocate concludes that children under the age of eight should not be cared for in shift-staffed group facilities.

(b) Theme – Supervision and Support Within the Shelter System

The report expresses concern about the supervision and support being provided for staff working in the shelter system. The Advocate suggests that staff need to have greater access to supervision that is done consistently and regularly. Of particular concern is the unavailability of direct supervision on the evening and night shifts for these 24-hour care facilities. The report recommends those responsible for supervising line staff (the shelter coordinators) receive training to better fulfil their human resources responsibilities. Related to this, the report contains a number of recommendations to ensure that policies and procedures are kept current, reflect the existing service needs and result in care that is delivered consistently throughout the shelter system. On the service environment, the Advocate finds that shelter staff feel isolated from the broader organization within which they work and there is a high level of tension in the labour-management relationship.

(c) Theme – System Oversight

The Child Protection Branch of Manitoba Family Services and Housing is currently responsible for developing standards and licensing residential care facilities for children (including shift staffed emergency care shelters). While there are detailed requirements that apply to all group care resources for children, the Advocate recommends that licensing and program standards be established specifically for emergency care placements. Emergency care should have its own set of standards to reflect its unique role in the continuum of substitute care for children. The report also suggests an additional staff person is needed so Child Protection Branch can adequately fulfil its licensing and monitoring functions, in the children's residential care system.

Another key element of system oversight in the shelter system is the role of the Provincial Abuse Investigator. Currently, the Provincial Abuse Investigator conducts a review when there is an allegation of abuse made against a staff person employed by the Winnipeg Child and Family Services Branch. The Advocate commends the work of the Investigator but suggests the role and mandate need to be expanded. Further, the report suggests that the Child Protection Branch needs an additional staff person to adequately perform the duties associated with an expanded mandate.

The Advocate's report is also critical of the process used to establish an annual budget for the shelter system in Winnipeg. The report expresses concern that the budgeting formula may create inequities between individual shelters and recommends that Manitoba Family Services and Housing review this budgeting and allocation process.

(d) Theme – Future Planning and Development

The Advocate provides clear direction for the future development of emergency placement resources for children. The report concludes the shelter system has developed incrementally, in response to immediate placement needs and in the absence of a coherent vision or comprehensive program model. A shortage of foster placements in Manitoba, a trend common throughout the country, was a key factor driving the expansion of the shelter system.

The report calls for a more coordinated and evidence-based approach to resource development. Improved data collection is required to determine the planning of placement resources that are responsive to the needs of children who require an emergency placement. The Advocate recommends a centralized capacity be established for developing placement resources throughout the province. This requires the Provincial Placement Desk be reconfigured, better coordination between Winnipeg Child and Family Services Branch and key service providers, and more cooperation between government departments.

(e) Theme – Leadership Role For the Four Child and Family Services Authorities

The Advocate consistently recommends the newly created child and family services Authorities play a leadership role in designing and implementing changes needed to achieve long-term improvements in the emergency care system. The analysis of admission data over a five-year period shows that Aboriginal children are over-represented in the shelter system, especially younger children (over the five years, 80 per cent of children aged four and under, placed into emergency care, were of Aboriginal ancestry). This analysis and support for the role of the Authorities reinforces the importance of the structural changes being implemented as part of the Aboriginal Justice Inquiry-Child Welfare Initiative.

4. MANITOBA FAMILY SERVICES AND HOUSING: RESPONSE AND ACTION PLAN

The Advocate's report contains over 70 individual recommendations. The report acknowledges that, given the historical development of the shelter system and the lack of alternate resources, there are "no quick fix solutions" to many of the complex challenges facing the shelter system.

The report's recommendations must be considered in the broader context of the AJI-CWI restructuring process. The actions taken by Manitoba Family Services and Housing must be done in a manner consistent with the AJI-CWI devolution and that respects the philosophy and partnership principles that support this important initiative. The Advocate reinforces the importance of this when she writes:

> "The shelter system affects the aboriginal community more than any other. In developing any new emergency care system we must be aware of the population it will primarily serve. Currently this system serves primarily Aboriginal children and youth and their families living in the City of Winnipeg. In planning any new system we must be cognizant of this very fact."

The findings and recommendations provide a blueprint for developing an emergency care system that has a clear direction and purpose within the broader context of all services intended to enhance the well-being of children. Along with a future-oriented blueprint, the report contains many practical recommendations that could have a more immediate impact on the quality of care being provided in the shelter system.

In response to the Advocate's report, Manitoba Family Services and Housing has developed a comprehensive action plan with four fundamental components:

1. Act immediately to create new emergency foster care resources specifically designed for children under age eight.
2. Immediately establish an Implementation Committee to address the Advocate's recommendations for future planning, system design and longer-term resource development.
3. Implement recommendations that will immediately have a positive impact on improving the quality of care in the shelter system.
4. Implement recommendations that will immediately strengthen the system oversight capacity.

The Assistant Deputy Minister of Child and Family Services and the Assistant Deputy Minister of Community Service Delivery will share overall responsibility for ensuring the four action plan strategies are implemented as intended and results achieved within expected timelines.

ACTION PLAN STRATEGY 1
Develop New Emergency Care Resources

The growth of the shelter system occurred, in part, due to a shortage of alternative placements. This placed a strain on the emergency care system and resulted in some children spending longer periods of time in shift-staffed care than is desirable. Such a resource shortage is not unique to Manitoba but is characteristic in child welfare systems throughout North America. Winnipeg Child and Family Services Branch recognized this issue and, in 2002/03, developed over 75 new, alternative placements to relieve pressure on the shelter system. The Advocate describes this as "admirable" and recommends the development of new resources continue but focus on recruiting foster care placements for younger children. The Advocate recommends, unless there are compelling reasons to do otherwise, that no child under the age of eight should be placed in a shift-staffed group environment. This is a foundational recommendation that will significantly alter the population served and ongoing role of the shelter system. In response, Manitoba Family Services and Housing will initiate the following action:

- Begin immediately to create 50 new emergency care foster beds specifically for children under the age of eight.

The four child and family services Authorities will, collectively, be responsible for establishing criteria and then selecting service providers to recruit foster parents for the 50 new beds. It's expected the new resources will be developed incrementally, with all 50 in place by the end of 2004/05, and it is anticipated this will eliminate the need for young children to be placed in the shelter system.

ACTION PLAN STRATEGY 2
Build a New Emergency Care System for Children

The Advocate's report contains numerous recommendations about how planning should occur for the future development of the shelter system. These are placed in the context of broader recommendations to re-configure the way residential care resources are organized. Collectively, these recommendations represent a blueprint for building a new system of emergency care for children that must be implemented in a systematic and organized manner, using an evidence-based approach to planning. To achieve this, Manitoba Family Services and Housing will:

- Immediately establish an Implementation Committee to act on the future planning and long-term recommendations in the Advocate's report.

The Implementation Committee will be co-chaired by Joy Cramer, Executive Director, Child Protection Branch, Manitoba Family Services and Housing; and Dr. Denis Bracken, Associate Professor, Faculty of Social Work, University of Manitoba. Dr. Bracken has extensive experience in managing complex planning processes and, in the role of co-chair, will provide an expert perspective that is independent from government and the child welfare system.

Consistent with the leadership role strongly supported by the Advocate, the Chief Executive Officers of each child and family services Authority have agreed to sit on this committee. A representative from Manitoba Family Services and Housing will complete the membership.

Terms of reference for the committee have been developed in consultation with the four Authorities (copy attached). The Implementation Committee will act on the major planning, governance and resource development recommendations in the Advocate's report. Taking an evidence-based planning approach, the committee will:

Step 1 Complete a province-wide assessment of residential care needs for children.

Step 2 Based on the results of the needs assessment, develop a proposed continuum of care and classification system for children's residential care.

Step 3 Within the context of the proposed continuum of care, develop a vision statement and comprehensive program model for the role of emergency placement facilities and services.

Step 4 Given the proposed program model, recommend standards and training strategy to ensure staff have the qualifications and competence to adequately meet the needs of children in emergency care.

Step 5 Assess the feasibility of implementing the Advocate's recommendations regarding a centralized office to oversee future resource developments, reconfigure the provincial placement desk, external governance of placement resources for children and a strategy for foster parent recruitment.

Manitoba Family Services and Housing will assign a full-time coordinator to assist the Implementation Committee in completing its work and, as recommended by the Advocate, one or more persons with extensive experience and expertise in children's residential care will be made available in an advisory capacity. The Implementation Committee will table a progress report within three months and submit a detailed plan within one year.

ACTION PLAN STRATEGY 3
Immediately Improve the Quality of Care in the Shelter System

While new resources are being developed and planning is underway for longer-term structural changes in the system, Manitoba Family Services and Housing will implement recommendations that will have an immediate and positive impact on improving the quality of care for children placed in emergency, short-term care. One of the key recommendations pertains to the staffing model used in the shelter system. The Advocate expresses concern that the practice of using 24-hour shifts is having a negative impact on staff's ability to deliver high quality care. Winnipeg Child and Family Services Branch has reduced the use of 24-hour shifts whenever possible and findings in the Advocate's report suggest this trend should continue. In response, Winnipeg Child and Family Services Branch will:

- Not use 24-hour shifts in any new shelter that is opened and continue to reduce and eventually eliminate 24-hour shifts in the existing shelter system.

Winnipeg Child and Family Services Branch is also responsible for acting on the Advocate's recommendations to improve supervision within the shelter system. In the existing organizational structure of Winnipeg Child and Family Services Branch, direct supervision of shelter staff is the responsibility of the "shelter coordinators." There are 11 coordinators and each one is responsible for a number of shelters. Recently, Winnipeg Child and Family Services Branch developed a "coordinator's protocol" that clearly outlines performance expectations in the areas of regular, on-site supervision, fiscal accountability and monitoring quality of care. A person with extensive experience in residential care was seconded to Winnipeg Child and Family Services Branch to mentor and coach the coordinators in using the new protocol. The Advocate commends these efforts and recommends this staff person continue to provide support to the coordinators. Manitoba Family Services and Housing agrees and will ensure this support function continues given the positive impact on supervision that has occurred.

Some of the Advocate's recommendations suggest further improvements can be achieved and staff may feel less isolated if the coordinator's protocol is expanded in certain areas. In response, Winnipeg Child and Family Services Branch will immediately amend the coordinator's protocol to:

- Increase the availability of supervision across all shifts in the shelter system;
- Ensure shelter staff have regular access to updates and other information routinely available to other staff in the Branch; and
- Ensure staff in the shelters inform children of their rights and provide children with information about the Office of the Children's Advocate and the Manitoba Youth in Care Network.

As noted in the Advocate's report, staff training is a key element of a quality care system for children. Winnipeg Child and Family Services Branch will ensure shelter coordinators attend the youth care competency based training program and offer additional training in performance management. Management will immediately review the training experiences of shelter staff and take measures to ensure the Branch complies with established standards and internal policies. Also, as recommended by the Advocate, Winnipeg Child and Family Services Branch will review, update and then communicate the provisions of the shelter policies and procedures manual and work with Internal Audit to prepare revised budget and funding allocations for the shelter system. Work in these areas will also begin immediately.

ACTION PLAN STRATEGY 4
Strengthen System Oversight

A number of recommendations in the report suggest improvements need to be made to the way quality of care is monitored. A key recommendation is that specific program standards need to be developed for emergency care placements rather than applying the broader residential care standards, that may not completely address the unique environment in the shelter system. Further, the Advocate suggests that Child Protection Branch is not equipped with sufficient resources to adequately fulfil the licensing and investigative responsibilities. Manitoba Family Services and Housing agrees with these recommendations and, immediately, will:

- Begin developing program standards specific to emergency placement facilities.
- Expand the mandate of the Provincial Abuse Investigator as proposed in the Advocate's report and develop a program standard to ensure the Investigator's reports are tracked and the recommendations followed.
- Add one more staff position to the Provincial Abuse Investigation Unit.
- Add one more staff position to the Licensing Unit.
- Expand the membership of the Provincial Placement desk so the composition is more multi-disciplinary in nature.

The Advocate's report also suggests Manitoba Family Services and Housing needs to work more closely with service providers and other government departments to ensure existing resources are being used effectively and that new placement resources are created to serve children with special needs. Manitoba Family Services and Housing also agrees with these recommendations and, in response, representatives from the Child Protection Branch will take the following actions:

- Initiate discussions with the Youth Emergency Crisis Stabilization System and Winnipeg Police Services to ensure resources are being used appropriately within the shelter system.
- Initiate discussions with service providers and other departments to consider how specialized resources can be developed to provide emergency care for siblings, children with disabilities and children leaving the Justice system.
- Meet with the Manitoba Foster Family Network to explore ways of supporting research into foster care breakdown, which appears to be a factor contributing to shelter usage.

Labour-Management Relations

The child and family services system in Manitoba is undergoing a restructuring of unprecedented magnitude and Winnipeg Child and Family Services Branch has undergone numerous organizational changes in the last 10 years. More recently, as noted in the Advocate's report, the shelter system has been more directly affected by the Branch's consolidation plan which began in early 2002. This plan reduced the number of shelter beds as new alternate placements were created and changed the way shift configurations are structured. With the Advocate's review completed, more changes are coming. Given that these changes in the shelter system are occurring in a broader environment characterized by the AJI-CWI restructuring, it is not unexpected that relations between labour and management would become strained. This tense relationship is cited as a concern in the Advocate's report.

Over the last 18 months, Winnipeg Child and Family Services Branch has made efforts to establish a cooperative working relationship with the union that represents shelter workers (local 2153 of the Canadian Union of Public Employees - CUPE). The former management board invited representatives from CUPE local 2153 to attend board meetings and to participate in a common table process with management and their colleagues from the Manitoba Government and General Employees' Union (MGEU). Recently, the government and CUPE local 2153 met to clarify provisions in the collective agreement and seek solutions to the union and workers' concerns while pursuing necessary changes to the shelter system.

It is hoped that these types of processes can continue to provide an opportunity for collaborative and productive discussions. Manitoba Family Services and Housing is committed to a fair and effective labour force adjustment strategy to assist workers who may be affected as the recommendations in the Advocate's report are implemented.

5. A COMMITMENT TO HEALTHY FAMILIES AND CHILDREN'S WELL-BEING

The review by the Children's Advocate considered one component of the child and family services system. This system, with its focus on child protection, is one part of a broader government responsibility to provide programs and services to support at-risk families and to enhance the well-being of all children. Research has clearly demonstrated the most effective child welfare policy is one in which key government systems work in an integrated manner to provide a holistic approach to supporting families. It has also been well-established that poverty is a key driver of referrals to child welfare systems throughout North America. Over the last few years, the Government of Manitoba has been pursuing a multi-faceted approach to addressing some of the underlying causes of family difficulty and expanding programs to improve income and program supports for children living in vulnerable families.

One example of this broader approach is the decision by the Manitoba government to restore the National Child Benefit Supplement for Manitoba families with children receiving income assistance. This supplement was fully restored in January 2004. In addition, earnings exemptions have increased for families on income assistance so they can keep a greater portion of income from employment. The annual school supply allowance has also been increased. All of these changes demonstrate a commitment to improving the financial resources available to Manitoba's poorest families.

Manitoba also continues to be a national leader in developing an integrated continuum of programs to support early childhood development. Healthy Child Manitoba is a long-term, cross-departmental strategy to promote healthy child and adolescent development. New and innovative services include: parent-child coalitions; prenatal and early childhood nutrition programs; healthy schools initiatives; a health adolescent development strategy; and Fetal Alcohol Syndrome/Fetal Alcohol Effect early intervention programs. These investments are critical to preventing family breakdown by providing early and effective support services to at-risk families.

Manitoba's Healthy Baby Program is another example of how government is providing preventative programs to support at-risk mothers. Through this program, women with lower incomes are provided with financial assistance to meet their nutritional needs during pregnancy. Community supports are also available to help pregnant women and new mothers learn more about nutrition, child development, and general health and wellness. This program, the first of its kind in Canada, has assisted over 4,000 expectant mothers.

In 2002, Manitoba's Five-Year Plan for Child Care was announced. Since 2000, funding for child care has been increased by over 40 per cent with much of this new funding intended to improve accessibility to quality day care for families living on lower incomes. The number of new funded, licensed spaces has increased by 3,500. These types of supports can greatly reduce the stress experienced by at-risk families.

Building the capacity of the larger community within which they live can also support at- risk families. Neighbourhoods Alive! is one program government has put in place to build community capacity. This is a long-term social and economic development strategy that encourages community-driven revitalization efforts in targeted neighbourhoods. Funds from the Neighbourhoods Alive! program can be used by local residents, businesses and community organizations to revitalize their neighbourhoods through physical improvements, employment and training initiatives and innovative approaches to recreation, safety and crime prevention. The well-being of children is enhanced whenever communities become stronger.

These are only some examples of how government has recognized its obligation to support at-risk families. In addition, Manitoba Family Services and Housing is working in partnership with the Winnipeg Regional Health Authority on a new, integrated service delivery model. Families will be able access a variety of services in a common location with multi-disciplinary teams providing health and social services, as part of a holistic response to meet the needs of families. This will result in a much more user-friendly, accessible and effective way to serve families and prevent children from coming into care.

Department of Family Services and Housing

SHELTER REVIEW IMPLEMENTATION COMMITTEE

TERMS OF REFERENCE

PURPOSE

The primary purpose of the Implementation Committee is to act on the planning and system development recommendations stated in the Shelter Review Report from the Office of the Children's Advocate. The Committee will submit a detailed implementation plan that addresses the future-oriented recommendations in the Children's Advocate's Report related to system governance, a mandate for emergency care, resource development and how best to oversee and manage the emergency and short-term care system in the longer term.

CHAIR

The Shelter Review Implementation Committee will be co-chaired by the Executive Director of the Child Protection Branch and a person external to government as selected by the Minister of Family Services and Housing. The co-chairs will preside over all meetings of the Implementation Committee and report jointly to the Assistant Deputy Minister of the Child and Family Services Division and the Assistant Deputy Minister of the Community Services Delivery Division within the Department of Family Services and Housing. In consultation with the other members, the co-chairs will select, supervise and direct any staff assigned to assist the Committee in completing its work.

MEMBERSHIP, STAFF AND CONSULTATION

The Implementation Committee will be comprised of the following members:

- The Chief Executive Officer or designate of the First Nations of Northern Manitoba Child and Family Services Authority.
- The Chief Executive Officer or designate of the First Nations of Southern Manitoba Child and Family Services Authority.
- The Chief Executive Officer or designate of the Metis Child and Family Services Authority.
- The Chief Executive Officer or designate of the Child and Family Services General Authority.
- Two representatives from the Department of Family Services and Housing.

A coordinator will be assigned to work with the Implementation Committee on a full-time basis. The Committee will select one or more persons with expertise in residential care to provide advice to the Committee on its work.

KEY ACTIVITIES

Consistent with the statement of purpose, the Implementation Committee will complete the following planning and research activities:

- Undertake a province-wide assessment of residential care needs for children currently in the care of the Child and Family Services System.

- Through research and trend analysis, determine the residential care resources that will likely be required to meet the needs of children coming into care of the Child and Family Services System over the next five years.

- Recommend a continuum of care and classification system for children's residential care based on the assessment of current and future need.

Based on findings derived from the planning and research activities, the Committee will develop a detailed implementation strategy that will:

- recommend a vision statement to guide the future development of emergency and short-term care resources for children within the new Child and Family Services System;

- propose a comprehensive program model to clearly articulate the purpose, goals and services to be provided within the emergency and short-term care system;

- recommend a set of standards unique to emergency and short-term care that reflect current best practice knowledge and Aboriginal culture;

- propose a comprehensive strategy to ensure that all staff working in the shelter system have the qualifications, training and competence to deliver a high quality and culturally sensitive service to meet the needs of children in emergency care;

- determine whether it is advisable to establish a centralized office for coordinating the future development of resources across Manitoba;

- propose revisions to strengthen the operation of the Provincial Placement Desk;

- recommend how emergency and short-term care in particular and residential care in general should be governed within the new Child and Family Services System in Manitoba;

- recommend a strategy for effective and coordinated recruitment of foster parents that is done consistently across all four Child and Family Services Authorities; and

- identify the costs, human resources, administrative and structural changes required to implement the recommendations contained in the plan.

MEETINGS, MINUTES AND PROGRESS REPORTS

The Committee will meet as often as required but not less than once a month. The co-chairs shall ensure that minutes are taken at each meeting in a format acceptable to the members. The full Committee will approve minutes. A copy of the minutes will be provided to the Minister of Family Services and Housing. The Committee will provide a progress report after three months and submit the plan (as outlined above) within twelve months.

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PROVINCIAL ACTION PLAN ADDRESSES RECOMMENDATIONS FROM CHILDREN'S ADVOCATE ON SHELTER SYSTEM: MELNICK

- - -

Minister Says Changes Already Made, Implementation Committee Overseeing Next Steps

Family Services and Housing Minister Christine Melnick has announced an action plan that responds to recommendations from the Office of the Children's Advocate for improvements to the short-term shelter system for children who are at risk.

The recommendations are part of a comprehensive review, requested by the provincial government and released by Melnick today, which was completed by the children's advocate.

"Some key issues came to light leading up to this review and we have already taken a number of steps to address those concerns," said Melnick. "The review shows children's needs are being met, however, other improvements are possible and we will address further changes to ensure the shelter system is better able to provide safe, supportive care to children in need."

The province's action plan identifies four key steps to be addressed immediately:

- creating 50 new spaces with foster care resources for children under age eight;
- establishing an implementation committee to further address major recommendations;
- implementing key recommendations to improve quality of care in the shelter system, such as increasing supports for shelter workers; and
- following through on recommendations to strengthen the system, such as hiring more staff for licensing and monitoring of shelters.

- more -

Before the review began and while it was underway, significant improvements were made to the shelter system, including:

- using shelters more effectively;
- redirecting resources from shelters to alternatives;
- strengthening on-site supervision and management of the shelter system; and
- improving training opportunities so staff could upgrade their knowledge and skills.

The implementation committee will be led by Joy Cramer, executive director, Child Protection Branch, Manitoba Family Services and Housing; and Dr. Denis Bracken, professor of social work, University of Manitoba. This committee includes representatives from the three Aboriginal child and family services authorities and the child and family services general authority.

The Office of the Children's Advocate completed the report after a 15-month process that involved an operational review of all aspects of the shelter system. The report has over 70 recommendations intended to improve the system.

"The children's advocate, Janet Mirwaldt, and the review team have provided a structure for important improvements and changes to the child shelter system," Melnick said. "They are to be commended for their excellent work and I will act aggressively on their advice."

With the creation of the new child and family services authorities, planning continues on the overall restructuring of the child and family services system throughout the province and this includes transferring responsibility for delivering short-term placement resources for children in temporary care. Manitoba Family Services and Housing, the four child and family services authorities, and the implementation committee will work together to ensure the delivery of culturally appropriate services.

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BACKGROUND INFORMATION ATTACHED.

SHELTER SYSTEM REVIEW REPORT

In December 2002, the minister of family services and housing requested that the Office of the Children's Advocate undertake a comprehensive review of the shelter system, in collaboration with the Child Protection Branch, Manitoba Family Services and Housing. This included:

- analysis of data from a five-year time span;
- discussions with key stakeholders;
- interviews with staff and children; and
- visits to over 40 shelter facilities.

The review was requested to look at the shelters providing children found in unstable family settings with much-needed short-term care. There are 130 beds in total at these shelters, staffed by qualified individuals on a 24-hour-a-day, seven-day-a-week basis.

These short-term placements provide safe and supportive care until the child can either return home or move into a stable, more permanent placement. Shelters are group care residences that range in size from two to six beds. Every effort is made to provide a home-like environment. In some cases, and only when absolutely necessary, children may be placed in a hotel (with adequate supervision) if a suitable shelter is not available.

A steering committee was also created to provide advice and support for the review. The intent of the review was to document and assess the system and make recommendations for improvements to the shelter system.

Planning continues for the transfer of much of the child and family services system in Winnipeg to three new Aboriginal child and family services authorities. This is part of the overall restructuring of the child and family services system throughout the province and this transfer includes responsibility for delivering short-term placement resources for children in temporary care.

Office of the
Children's Advocate

Review of the Operation of the
Winnipeg Child &
Family Services

Emergency Assessment Placement Department (EAPD) Shelter System

March 2004

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EXECUTIVE SUMMARY

In December 2002, the Honourable Minister of Family Services and Housing Drew Caldwell, requested that the Office of the Children's Advocate complete a review into the operation of Winnipeg Child and Family Services (WCFS), Emergency Assessment Placement Department (EAPD) shelter system. Its purpose was to document and assess the shelter system and to make recommendations on the use of shelters to care for children and youth. In addition the review was to provide a forum for the voices of children and youth residing in the shelters system.

A three-member team composed of Janet Mirwaldt, the Children's Advocate and Children's Advocacy Officers Jill Perron and Susan Thomas conducted the review. A shelter review advisory committee made up of members from Voices Manitoba Youth in Care, Marymound Inc. and the Department of Family Services and Housing (DFSH) assisted the review team.

Main Findings

Resource Crisis

There is a national shortage of foster homes and other family based setting across Canada. More importantly to Manitoba there is a lack of culturally appropriate foster homes or family-based settings. The belief of many WCFS staff interviewed was that children and youth in care have higher needs than those previously seen. As well, the agency complained that alternative community care resources were slow to develop to meet the identified need, leaving WCFS with little option but to create its own.

There appeared to be no consistent vision and coordination of resource development across the Province. Resources were often built in a response to a crisis. Our CFS system needs to develop the capacity for community resource development for out of home care for children and youth in a systematic and planned fashion.

Licensing and Monitoring of Care

The DFSH is responsible for licensing of all residential care beds inclusive of the EAPD shelter system. Prior to changes in *The Child and Family Services Act* in 1999 the shelters were unlicensed. Though both WCFS and the DFSH were aware and began discussions to expedite the licensing process, neither appeared ready to fully absorb the shelter system into this process. The DFSH provided a broad level of latitude to the agency to get the shelters licensed. During this time the agency continued to open new shelters. Had the facilities been required to qualify for licensing at the onset and prior to any new facility opening, the level of scrutiny would have been higher.

Prior to the changes in legislation the concept of emergency shelter care was not a concept well understood by the DFSH. The current standards do not address the uniqueness of emergency shelter care. As well, licensing standards and regulations are intended to operate as minimal guidelines. The quality of care is left entirely to the discretion of the facility operator. There is no ability for the DFSH to ensure that the facilities exceed minimal standards.

The DFSH is also responsible to monitor care and investigate any allegations of child abuse made against staff. Currently the DFSH has insufficient staffing to ensure this responsibility is adequately carried out.

Historical Development of the EAPD-Shelter System

The EAPD shelter system developed over a period of 10 years and was a response to a resource crisis. When first designed, the shelter system was based on a foster care model but as resources were needed and fewer individuals were prepared to 'foster', the system drifted towards shift-staff care. This drift was not intentional. The agency, through the creation of guaranteed 12 and 24 hour shifts, moved to stabilize their work force while attempting to support its service philosophy of consistent single caregiver. Due to a lack of qualified foster care providers the original model shifted from a foster care model to a quasi-foster caregiver model and finally to a permanent shift staff residential care model.

At the same time the agency was attempting to provide services while reacting to an ever-changing environment. These larger environmental pressures resulted in ongoing structural and staffing changes. The agency reorganization to a Program Model centralized Human Resource supports to head office. Shelter co-ordinators were left without adequate human resource supports. Supports needed to assist in the shift to a residential care model. The Program Model also attempted to connect Quality Assurance and Community Development programs to EAPD but given the ongoing changes to the agency structure this connection was never fully realized or supported.

In conjunction with and following the agency's reorganization, senior managers' time and attention was diverted from program development to larger systemic initiatives, leaving EAPD staff to develop the program in isolation. The program continued to grow in-care capacity without adequate program evaluation and development to support that capacity. In the end, the program did not develop or articulate a program model that defined its goals, objectives, resources, program activities and/or outcomes.

Where Children and Youth are Living

At the time of this review, EAPD had 51 facilities, all but one of them licensed. Eight of the homes were owned by the agency, 31 rented from private landlords or through real estate companies, and 12 were created through co-operative partnerships with Manitoba Housing Authority (MHA).

The review team visited 47 premises. Most were in acceptable condition, but there were some that were not. Most of these shelters in one area - which contained 24 per cent of the EAPD facilities - were deemed unacceptable because of the neighborhood's observable criminal and anti-social activity (drug trade, adult sex trade) gang activity, abandoned homes, and high incidence of reported crime. Three shelters were deplorable. These were pointed out to the agency and the shelters were subsequently closed.

Many shelters showed attempts were being made to provide a home-like environment. Overall, however, the provision of a home like environment was inconsistent. There were varying levels of effort made by staff to provide home-like environments and undertake routine maintenance. In some shelters, staff undertook maintenance and decorating chores, but in others staff have reported simply to telling shelter co-ordinators that a light bulb needed to be replaced.

Though there were complaints of over crowding in the shelters the OCA found no evidence that this occurred. Our inspections did confirm that the EAPD has rented homes with no way to monitor slow or negligent landlords. We observed mold, overflowing toilets, windows without screens, and water flowing in the basements of some shelters.

Overall, the OCA found that the basic care provided to children and youth to be adequate. Children and youth reported that routines were established in the shelters, they received adequate nourishment and were involved in daily activities. Personal hygiene items were provided. Some issues pertaining to inadequate clothing were brought forward by youth that reported difficulties in contacting their social worker that then could authorize purchase of clothing.

Children and Youth Living in the Shelter System

Overall WCFS had difficulty identifying the population served by the shelter system. What the OCA found was 3085 children were placed in the EAPD emergency care system between 1998 to 2003. Of these 2,318 children and youth were placed in EAPD shelters. Those children who resided in the shelters stayed an average of 44 days. Sixty percent of the children and youth exit the shelters within 60 days, but 40 per cent remain longer. Sixty per cent were 11 or younger, and 25 per cent three or younger. Forty-three per cent were female, 57 per cent male. More than half of all children entered EAPD system (shelters and other emergency care) from the foster care system.

In the WCFS EAPD system 62 per cent of the children and youth placed were aboriginal; approximately 43 per cent held treaty status. Of the aboriginal children and youth placed in emergency care, most were under 11 years of age. Alarmingly, compared with non-aboriginal placements, a large percentage of these children were 4 or younger. As well when the OCA looked at the youth population we found that non-aboriginal youth (ages 12 to 17) were more often placed in emergency care other than the shelters, than were aboriginal youth.

Though the majority of all children and youth enter emergency placements from foster care a higher percentage of non-aboriginal children and youth come from foster care (61.5 per cent) than aboriginal children and youth (45.5 per cent). A higher frequency of aboriginal children and youth (35 per cent) enter shelters from hotels as compared to their non-aboriginal peers (17 per cent). Aboriginal children and youth are more likely to enter emergency care under apprehension than their non-aboriginal peers.

The Program

No program model has been developed for the EAPD shelter system. Policies and procedures, which outline the care of children, were often developed in reaction to events and pressures. The agency had a responsibility to ensure that clear, concise policy and procedures were created, and that these reflected and articulated how emergency care would be provided to children and youth. The Home Manual, which provided some definition of care, has not been kept up to date. The review found that many shelter employees consider the manual to be just guidelines rather than rules and regulations. This attitude along with the high use of purchased service staff allowed for the inconsistency of care across and between the shelters.

Overall, however, WCFS staff appeared qualified and committed to their chosen field. The majority of shelter staff make every effort to provide adequate basic care. The shelter system is, however, responsible for caring for all children and youth ages 0 to 17, all of whom may possess uniquely different needs. High needs children and youth are often placed in the shelters given the lack of other community resources to care for them. Shelter staff, though well intentioned, appeared ill equipped and or supported to meet these needs.

Shelter staff lack supervisory support. Supervision is inconsistent and does not occur across all shifts. Coupled with inconsistent supervision, staff development and training opportunities are limited, as there is no comprehensive continuing training program for shelter staff or co-ordinators. As the system grew, so did the need for staff and in many cases this need was provided by outside contractors, which presented supervision and training issues.

The EAPD system was to provide innovative programming for children and youth in their care. There are no formal programs offered. Recreational opportunities are provided, however, this is inconsistent and what is offered can include a wide variety of opportunities ranging from recreational activities two or three times a week or simply watching TV or going to the movies.

Staff and shelter co-ordinators agree that children are not always appropriately matched for admission into shelters. Older children complained that they were housed with infants and toddlers; youth complained that the inappropriate matching of residents could lead to problems inside the shelters among the residents. Staff as well complained that the inappropriate matching could cause safety issues inside the shelters. Further, children and youth who exhibit profound developmental delay or who are multiply handicapped, are isolated from other children and can remain in shelter for extended periods of time awaiting specialized placements.

Often when children are apprehended under emergency circumstances and admitted to shelters there is limited information available about them. Staff and co-ordinators complained that they often lacked information they need to ensure appropriate care from the outset. They also reported that there were time delays in receiving information once it was available to the social worker about the child or youth. They also report difficulty for both shelter staff and the children to make contact easily with the children's social workers.

Family visits are usually prohibited in the shelters, although telephone contact is allowed. Similarly, peers are frequently not allowed to visit those in the shelters and social use of the telephone is restricted.

School attendance for children in the shelters is inconsistent at best. Shelter staff reported that almost one third of children entering the EAPD do not attend school after admission. Because the children are often in shelters away from their schools, it is difficult to get them to their schools or to enroll them in new ones.

Behaviour management of children and youth is primarily accomplished through loss of privileges, but 20 per cent of staff interviewed stated they had physically restrained children between the ages of 6 to 12. Sixty-eight per cent of staff said they have used physical restraints during their careers with WCFS. Despite WCFS having a policy with respect to the use of physical restraints, shelter staff were inconsistently aware of its content. Reporting and documenting of incidents inside the shelters was also inconsistent internal to WCFS and externally to the DFSH.

Staff stated that discharge planning was the most uncoordinated component within the EAPD system. Although children and youth are supposed to be involved in the planning, few are. And they often have very little time to prepare to leave a shelter and move to another placement.

Staff reported that many children are not aware of their rights or of any grievance procedures, and that in some shelters children are not encouraged to contact the Office of the Children's Advocate (OCA), nor are staff members allowed to contact the OCA on the child's behalf.

Staff/Management Relationships

During the review, the OCA became aware of continuing tension between the staff and management in the EAPD shelter system, and concluded that at times this relationship affected the care of children and youth.

Tension mounted when the agency began consolidating EAPD operations. Because they work in small groups or alone, EAPD shelter workers had always felt isolated. As one part of the consolidation plan, the agency had considered amalgamating some smaller shelters to develop larger shelters inclusive of six bed shelters. Management identified the 12- and 24-hour guaranteed shifts and their perceived restrictions on redeployment of staff as a significant problem in the plan.

At this time there developed an antagonistic work environment, with little trust between workers and managers. Problematic staff performance was not seen as being effectively dealt with by any one group. This has impacted upon morale within the program, extending into the shelter environment.

The Costs of Care

The costs of care, and the demand for the emergency shelter service, continued to rise during the five-year period studied. During our review, the OCA heard allegations that the shelters were not adequately funded.

Each shelter is provided funds on a semi-monthly basis to purchase food, household items and provide recreational opportunities for children and youth based on their assigned but not necessarily filled bed spaces. Individual shelters receive allotments based on bed capacity for food, clothing and incremental items. They receive the full allotment whether the beds are occupied or not, on the grounds that in an emergency system the shelters have to be ready at all times to operate at full capacity. Assigned staff are responsible for these expenditures.

Though the agency's fundamental financial controls were found to be adequate there were a number of issues regarding the implementation of procedures. Primarily, the shelter system lacks a formal procedure manual to guide co-ordinators and staff in the management of the allotments or disbursements. The use of contract staff in some of the shelters made it difficult for some shelters to fully implement the procedures in place. The degree of monitoring procedure implementation, a responsibility of the shelter co-ordinators, varied among co-ordinators.

Further and fundamental to the daily operation of the shelters, and the care of children and youth, was the determination of the allotments provided to the shelters. Establishing rates for care premised on bed space is contrary to other funding models. The current funding allotment for food is expected to cover the cost of feeding both staff and residents, but the rates are not adjusted to cover additional staff when they are required. The current allotment methodology forces some shelters to manage more frugally than others. "Shelter staff occasionally cope with tight budgets by temporarily 'lending' their own funds to meet the needs until the next allotment cheque arrives or resorting to no-cost recreation or cheaper food".

The review found no valid process to determine the monthly allotments or realistic EAPD budget; at times, budgeting was based on unrealistic assumptions (reduction of days in care) leaving the agency with little ability to effectively analyze or reasonably project costs. The 2002 to 2003 budget for the shelters "was established at a level 41.7 per cent lower than the prior year's actual expenditures. The estimated number of days in care, which is the primary basis for the budget, was 35.5 per cent lower that the prior year's actuals. The rationale for these reductions was not readily evident." This process contributed to the agency going over budget.

Summary

The OCA has noted that the DFSH has made efforts in various initiatives to create a number of alternate care resources for children, in addition to the efforts made to effect change inside the EAPD shelter system. However, this review has found little evidence that substantial change has taken place within the WCFS EAPD shelter system. There remain deep-seated suspicions within the organization and there still appears at times to be an adversarial relationship with DFSH.

A lack of leadership and direction had a direct and negative impact on the EAPD program development. There is a distinct lack of a feeling of ownership and accountability among those involved. It was unclear to those who worked in them what the purpose of the shelters was, and when the model evolved from one using foster parents to one using paid staff, no new supervisory or management tools were provided.

Recommendations

- Development of a true continuum of care model for children and youth, including preventive care, more in-home support and a wider range of out-of-home services including shelters and specialized accommodation for special needs.
- Creation of a Community Resource Development Office to assess the resources and needs of Manitoba communities. This body would co-ordinate among agencies to systematically plan needed resources. It would also create a standardized classification system for all out-of-home resources.
- The development of a multi-disciplinary Provincial Placement Desk to co-ordinate placements in facilities best suited to the needs of specific children and youth.
- DFSH should post, on a secure website, an inventory of all placement vacancies so that professionals in the field can better plan for placement of children and youth.
- The Provincial Abuse Investigator's office should be expanded and mandate extended to include all concerns related to questionable child-care management, with procedures to ensure that action is taken.
- DFSH, with the help of the Internal Audit service, develop a realistic budget for WCFS and the EAPD system and that DFSH take direct control of the EAPD system until budgets and a proper program model are in place.
- Appointment of an Educational Specialist to resolve problems relating to education for children and youth in the shelters and a Health Specialist to ensure that there is ready access to medical advice and service.
- Improvement of supervision in shelters and access for all shelter employees to supervisors, and creation of a position specifically for co-ordination and operation of the shelter system. Team-building through staff meetings held at least once a month.
- Training for staff and purchased-service employees should be provided to bring all up to standards, with a continuing training program.

- Improved HR support and performance reviews.
- Establishment of licensing standards for emergency shelters and increased inspection and enforcement from DFSH.
- No children under the age of 7 should be placed in group care emergency facilities unless there are specific defined reasons involving special needs or special competency in a group care facility.
- Shelters should operate on an eight to ten-hour shift configuration, with one staff member for every two children/ youth placed.
- Shelters of up to six beds to accommodate sibling groups.
- More attention to placement and care for special needs children including multi-disciplinary teams working province-wide to provide planning and care.
- Children should be aware of their rights, including their right to contact the Office of the Children's Advocate and youth should be advised of the assistance available from Voices Manitoba's Youth in Care.
- Greater efforts to recruit and retain foster parents.

PART 1: INTRODUCTION

A critical review of Winnipeg Child and Family Services (WCFS) Emergency Assessment Placement Department (EAPD) shelter system has been undertaken by the Office of the Children's Advocate (OCA) in partnership with the Department of Family Services and Housing (DFSH). The focal point of this review is the children and youth in the EAPD shelters.

Children and youth that are assessed to be at-risk and entering the child welfare system through an agency might do so for a variety of reasons such as sexual abuse, physical abuse and neglect. Children and youth might also enter into the system as a result of issues not pertaining to their family's ability to protect and/or parent them but due to circumstances that require the family to be assisted in caring for their children. When children are at-risk of harm or families require assistance in caring for their children an out-of-home placement can be required. Children and youth already inside the child welfare system, and at times other child caring systems (justice, health), can also require, due to a variety of reasons, different out-of-home care arrangements than originally planned. Within WCFS, once it has been determined that a child or youth requires separation from the familial home, for a period of time, or from a previous out-of-home placement, a placement is requested from the agency's internal placement desk. A subsequent referral may then be made to the agency's EAPD for temporary placement within the emergency shelters.

Once a child has been placed in a short-term emergency shelter, planning for this child during and after the stay has to occur. For some children, emergency shelter placement provides temporary accommodation while the agency addresses the issues with the family, that resulted in the child entering care and begins the process of family reunification. For children who enter the shelter system from an alternate care resource, or for those for whom reunification is not a viable option, a planning meeting would be organized with the appropriate agency people. These people usually are the social worker, shelter staff, foster care department and should include the child (where age appropriate) and parents (where it is possible). The purpose of the planning meeting would be to identify suitable long-term placements because the EAPD shelter system is intended to provide emergency short-term care only.

Emergency shelters are licensed and regulated under the Provincial Residential Care Licensing and Standards, and should be reflective of best practice standards. Residential Care Standards are supposed to ensure that children coming into care are afforded the best possible care. Children and youth in the shelters are entitled to basic care in a home-like setting, complete with safety and protection, shelter, food, clothing, medical, education and recreational activities. There must also be planning for a long-term suitable placement, provision of access to family, siblings and identified community. The child's right to participate in that community also must be safeguarded.

The OCA will examine and critically assess the quality of care provided to children and youth within the EAPD shelters in light of best practice standards determined by Provincial Residential Care Licensing Standards, and the Child Welfare League of America's Standards of Excellence in Residential Care. Undertaking this assessment requires consideration be given to these questions:

- What is the definition of a "shelter"?

- regulations and standards sanction the operation of shelters and the services provided therein?
- To what standards and regulations should shelters minimally adhere?
- Where does the shelter system fit along the care continuum, and whom does it serve?
- If shelters are a necessary placement alternative, what standards have to be applied to ensure children receive quality care?
- What should occur for children and youth in the shelter?
- What can children and their families expect in terms of care and suitable treatment planning?
- What needs to be present to ensure best practice outcomes for children and their parents?
- What is the cost of operating a shelter system?
- Does a program evaluation find that adequate care and services are provided within the program's cost?
- What internal and external factors impact favourably and/or adversely upon the quality of care received by children and youth within the shelter system?
- How does the shelter system interact with the collateral involvement needed to ensure children and youth receive a complement of total services?

The OCA undertook a comprehensive review of the shelter system, its growing demand and its attempt to meet the many critical placement needs of children and youth. The review required a high level of collaboration and co-operativeness from the DFSH and WCFS and its EAP Department. The focus of the Shelter Review has to be on the consumers of this emergency service-the children and youth who require its care and supervision.

The OCA recognizes the environment in which WCFS programs are delivered and the pressures placed on all child and family service agencies in Canada to provide services. Currently there are 76, 000 children and youth in care across Canada. In Western Canada 68 per cent of children and youth in care are aboriginal children and youth. The number of family-based care homes (adoptive, foster, kinship, customary and guardianship care) has significantly decreased (for a National and Provincial Overview please see Appendix 2).

PART 2: BACKGROUND

Purpose of the Review

In December 2002, the Honourable Minister of Family Services and Housing, Drew Caldwell, requested that the Office of the Children's Advocate (OCA) complete a review into the operation of Winnipeg Child and Family Services (WCFS), Emergency Assessment Placement Department (EAPD) shelter system. The review was to document and assess the WCFS shelter system and make recommendations on the use of shelters to care for children and youth. The Children's Advocate under *The Child and Family Services Act* has the authority to conduct such inquiries and be furnished with any information, the advocate believes is required to complete her investigations.

This review was precipitated by concerns that had been publicly raised to the Minister's office and to the OCA about the quality of care in the WCFS shelter system. Concerns were also raised about the safety of children and the staff, the cost of the program and the impact that shelter care may have upon children and youth.

The OCA, in collaboration with the DFSH, identified key areas to be assessed. The OCA would provide:

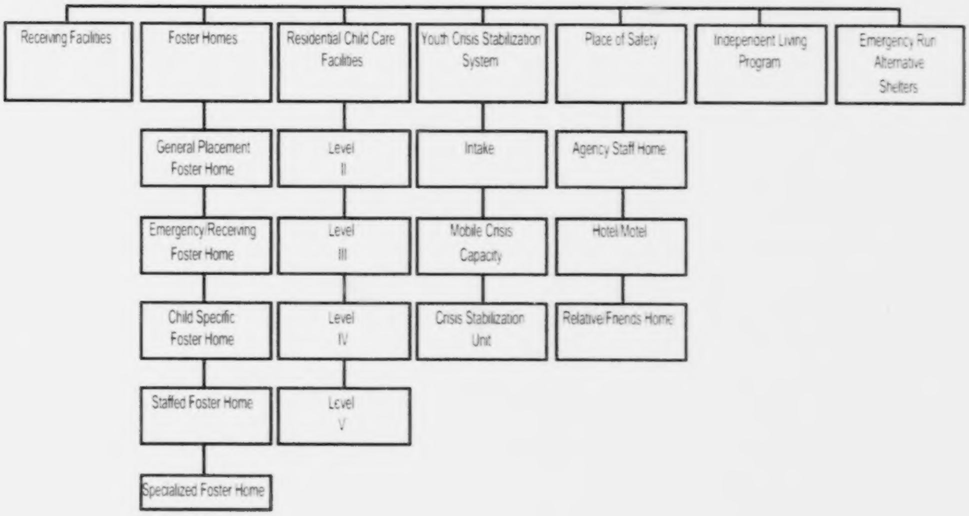
- A description of the shelter system's design, policies and procedures.
- Analyses of how the shelter system fits into the continuum of services offered and comment on the receiving capacity for emergency placements in the current child and family services system in Winnipeg.
- A description of the children and youth who currently use the shelter system. Further, the OCA would listen to their experiences in the shelter system and their perceptions of shelter care.
- Identify the benefits as well as the issues and pressures on the shelter system.

The primary purpose of the review was to provide a forum for the voices of children and youth within the WCFS shelter system. Personal interviews were conducted using a random sample of children and youth who were in the shelter system. We recognize that thousands of children and youth have been served by the WCFS shelter system, and that it was not possible to interview all. We completed an analysis of available statistical data for a five-year period to reflect the experiences of those who could not be interviewed. We believe that combining one-on-one interviews with statistical analysis has given us the ability to animate their voices.

Provincial Substitute Care Resources

The Child and Family Services Act indicates each mandated agency has a "duty to provide care for children in its care, and to develop and maintain child care resources" (CFS Act, 1999:14). This legislation outlines the type of provincial funded out of home care facilities that are available for agencies to develop internally, or for agencies to purchase services externally from non-mandated agencies, for the provision of alternate care when a child has been removed from a parental or a familial home. These care facilities, be it foster homes, residential care, or other care alternatives are licensed and regulated to ensure minimum standards are met and acceptable levels of care are provided to the child. These care facilities should exist within a resource continuum.

Manitoba Substitute Child Care Resources


Receiving Facilities
Foster Homes
Residential Child Care Facilities
Youth Crisis Stabilization System
Place of Safety
Independent Living Program
Emergency Run Alternative Shelters
General Placement Foster Home
Emergency/Receiving Foster Home
Child Specific Foster Home
Staffed Foster Home
Specialized Foster Home
Level II
Level III
Level IV
Level V
Intake
Mobile Crisis Capacity
Crisis Stabilization Unit
Agency Staff Home
Hotel/Motel
Relative/Friends Home

Substitutional care is not the only resource that is available to CFS social workers when they are working with a family. In a full resource continuum, resources can be inclusive of services provided in a family home that support and/or supplement the care of the child, in addition to out of home substitutional care resources. This range of resources can be integrative, or utilized in tandem with one another. It would appear that services provided within the substitute out of home care resources, are not a part of a true service continuum. A continuum that follows a child regardless of care status and provides a succession and where needed an integration of a range of preventative, supportive, supplementary and substitutional care services.

When children and youth enter into the emergency care system the limitations of services is even more profound. It is within the resource of "Emergency Run Alternatives: Shelters" specific to WCFS EAPD Shelter System, that this review will focus.

PART 3: HISTORICAL DEVELOPMENT OF THE SHELTER SYSTEM

Winnipeg Child and Family Services Inc.

WCFS has provided a variety of temporary placement settings to accommodate children and youth that required emergency or short-term care. The types of settings varied amongst the previous geographical service areas of WCFS, and within the more recent Program Management structure of the agency. The capacity of this resource was affected by internal pressures for resource development through times of organizational change, pressure from the OCA to reduce hotel usage and the external pressures caused by treatment facility closures, fiscal accountability, and licensing requirements.

In 1991, WCFS operated within four geographical service areas, each with its own model of emergency temporary care. These models of care ranged from foster homes operated by individual community members in their own homes to the use of hotels with paid agency staff, supplemented by staff from purchased service agencies. There were also paid professional parents in homes owned by the agency who provided emergency care to children within a six to eight bed receiving home model, licensed by the Residential Care Licensing Branch. As well, the agency employed childcare staff to work shifts within an agency-owned home designated to provide emergency care.

During the 1990s, the agency began to experience a shortage in foster care and an increase in the cost of treatment foster homes. The agency adopted a housing policy that created age specific four-bed units to provide short term emergency care.

Two models emerged to address the systemic need within WCFS for short-term emergency care.[1] The first model, nine facilities in WCFS-Northwest Area, was a system of alternative care referred to as Four Bed Homes. These facilities were to provide short-term emergency programs that would provide assessments and planning recommendations for a child's future placement. In five of the nine facilities, the primary caregiver lived in an agency home, providing a home-like environment for high needs children, youth, and adolescents who were parenting their infants. Foster parents and support staff assisted children and youth in transitioning to appropriately identified residential care facilities, treatment foster homes, foster homes, familial homes and or independent living. These facilities were youth-focused, maintaining loosely defined program parameters to meet the needs of the residents. Each of these five homes was unique to the needs of the residents, and this determined the acceptable length of stay. There were also four shelters operated by staff. These shelters were for children 11 years and younger when no foster homes were available. The focus of these programs was to provide assessments and emergency care until foster homes became available. All of the Northwest shelter and emergency care homes were administered under the foster care program.

The second model was the WCFS-Central Area receiving home model. In the Central Area there were two eight-bed units, staffed with agency child-care workers who worked eight-hour shifts. The target population ranged from children aged eight to youth aged 17. Children and youth in the targeted age range could be placed in either home. The child-staff ratio was flexible, depending upon the needs of the children served. These facilities were licensed under Residential Care Licensing Branch as temporary emergency care. Although the intent was emergency temporary care, stays ranged from a day to six months or more.

In 1995, the eight-bed receiving home model was dissolved into the four-bed unit model. WCFS-Central Area now operated four facilities that were staffed with agency child-care staff now working eight to 12 hour shifts. The four-bed units became more age specific, with intent to move children and youth into more viable foster care alternatives.

In 1997, an operational review of WCFS conducted by Prairie Research Associates[2] (PR) identified many areas of service that contributed to the growth in agency expenditures. One of the main findings of the review was that "the foster care and emergency housing system (including residential care) are failing and are forcing the agency to rely on expensive alternatives such as hotels and expensive residential placements." (Prairie Research Associates, 1997:p. ii). The PR review said the problems in WCFS emergency housing were exacerbated by the agency's lack of coordinated service delivery, a fragmentary evaluation and information capability.

At the time of the PR review, WCFS supplemented the four-bed units by using a number of receiving homes, renting a number of apartments for temporary placements as well as hotel/motel accommodations.[3] Faced with this mosaic of care models within the system, a growing shortage of foster homes and the high needs of children who were experiencing family or alternate placement breakdown, WCFS executive management decided to develop a single system of temporary emergency care.

The primary objective of this system of care was to create connections with placement resources to assist children in moving from shelter or temporary emergency care into more long-term care, or residential care options. The idea was to design the home around the needs of the child (i.e. Mom's and Babes) using a licensed foster parent residing in an agency home, supported by an agency team of respite and support workers. Because there were not enough qualified foster parents willing to reside in an agency home, this fundamental component was altered, and professional staff working shifts operated the units.

While developing the new emergency care system, WCFS also began a strategic planning process to attempt to implement the recommendations of the PR report. Specifically, the agency focus centered on a concept of central management co-ordination with local service delivery operating by functional responsibilities. The agency's emergency care system now became the Emergency Assessment Placement Department (EAPD).

The Shelter System (1996-1997)

A committee, including members of the Northwest Area and Central Area WCFS executive management, assigned the four-bed home coordinator in Northwest Area to implement a similar program in the Central Area following the foster parent model. The aim was to try to compensate for a shortage of placement resources for children and youth coming into care, to facilitate reunification for young children and large sibling groups entering care, and to develop resources for children and youth who were experiencing foster placement breakdown. It was also designed to provide adequate supervision, support and mentoring to assist young parents. A secondary focus of the program found its impetus in financial accountability and the need to reduce the number of children who were placed within unlicensed, unregulated hotel placements.

The program's initial model, premised upon the Northwest Area model, was to use a home purchased or rented by the agency and a professional caregiver that would live in the home. The home was licensed as a four-bed shelter where a foster parent would be the primary caregiver.

The intent was to provide a safe, stable environment where functional strength-based assessments[4] could be completed to assist social workers in case management as it pertained to determining suitability of future placement. Providing stability for the child, ensuring continuity of planning, and inclusion of children in the planning process were all integral goals.

Despite the transitory nature of the four-bed shelters,[5] the program emphasized creation of stability through the provision of nurturing care, daily routine, structure and recreation. A fundamental component was the implementation of a four-bed coordinator who would assist the foster caregiver in completing the functional assessments and provide liaison with alternate care resources, such as, schools, probation officers and medical personnel. The coordinator's role was to further support the foster parent through the use of respite and program workers. Each home offered a program based upon the needs of the specified targeted population. By the fall of 1997, there were 14 operational shelter homes.

The program also developed a mission statement, policy and procedures, and a loose definition of short-term care - less than one month. The statement said children might stay more than a month if it made sense in care planning; if, for example, reunification with family were imminent. However, if reunification were anticipated to take longer than two months, the expectation was that the child(ren) would be moved to a foster home.

It should be noted that during this time, the program remained focused on service delivery within the Northwest and Central Areas of WCFS.[6] Those operating the facilities were considered to be professional foster parents who were paid a flat per diem rate while payment for the rental of the home was covered by the agency. There was provision for support and respite hours from professional staff to cover vacation time for the caregiver.

The agency saw this new form of emergency housing as a way to de-institutionalize care, to counter the decrease in the recruitment of private foster homes, and cope with the reduction of provincially-funded low level residential care beds. (PR, 1997).

The EAPD Shelter System (1997-2001)

EAPD was formally developed as a stand-alone department within WCFS in 1997. It was an amalgamation of the Northwest and Central Areas' models of shelter, receiving homes and hotel resources. Because of the focus on a stable home-like environment, location was of primary importance when the agency selected homes to rent. The homes needed to be near community resources. The school division, level of service and communication provided by to the agency were important factors. Others included the home's proximity to schools, parks, daycare, and bus routes. WCFS Accounting Department would establish a budget for purchase or rental of the home. Once homes were purchased or rented, staff were licensed and then moved in.

The EAPD role was to serve whenever there was an absence of placement resources, either internal or external to the agency. At the outset of the program, EAPD worked collaboratively with the foster placement department to profile children in an effort to determine suitable resource matches. Reportedly this collaborative approach assisted the EAPD program in meeting its mandate in providing continuity in planning while maintaining shelter placements on a short-term basis.[7]

The original Northwest area four-bed foster model was quickly eroded by the lack of qualified professional parents who were willing to reside in the agency's receiving homes and provide consistent and stable care. The loss of consistent caregivers meant the use of agency childcare workers, working shifts, to maintain the operation of the home until another suitable caregiver could be found. Unfortunately, the increased use of shift staff was perpetuated by the continual loss of parent caregivers.

EAPD continued to experience pressure from the agency's foster system to create resources for children and youth. In the spring of 1998, the WCFS agency after hours was centralized and subsequently, EAPD expanded to include agency-wide emergency housing. Typically demands arose from resource crises that included: a lack of available placements for a child at admission to care, foster home breakdowns, transitions from foster care to group care and vice versa, and a lack of available treatment beds for high-needs children who required specialized care.

The agency approached these placement demands in a variety of different ways, but there were two underlying goals:

- Ensure children and youth were placed in or at close proximity to their community.
- The placement of children and youth in hotels was to be a last resort.[11]

The agency believed that hotels were used for cases that fit into three categories and that they could be adequately served by EAPD. These categories were identified as follows:[12]

i. Large volume of children entering in and out of care for short periods of time due to a temporary incapacity of parent, or to abate crisis within familial homes.

ii. Mandated protection cases that were referred to the agency by community. These cases required a planned apprehension that arose from the agency follow-up and assessment of the reported concerns.

iii. Children already in care of the agency, who experience placement breakdown from regular foster care, paid professional parent homes or residential care. These children require temporary placement to enable the worker to reassess the child's needs and develop an appropriate alternative care plan.

The identified needs of children varied from those that required one-on-one supervision, to those who had to be separated from siblings due to risk factors, to large sibling groups who required a single placement. These needs often required the creation of placement settings from multiple beds (four to five), to double and single bed settings. The EAPD program created additional beds to meet the needs of clusters of children. The EAPD also attempted to institute programming in the shelters, creating recreational and cultural opportunities for children to participate in the arts, athletics, and cultural activities within the community. The EAPD prided itself on its flexibility in being able to meet the individual needs of all the children it served. However, creating this capacity occurred through rapid expansion of the EAPD resource, from 16 homes in 1998 to 72 homes by the end of the 2001 fiscal year, utilizing a staff caregiver model.

Simultaneous to the pressures to create resources, there were organizational changes within WCFS that had an impact upon the EAP department. WCFS was moving service delivery from the geographical, community-based model, to one of more central program management. This fundamental shift in organizational and administrative structure diverted the energies of executive management to strategic planning, thereby leaving little emphasis on the role of the steering committee for EAPD. The steering committee ceased to be operational once EAPD fell under the larger service program Resources in Support of Services. The lack of consistent input from executive management left the EAPD responding to crisis, meeting the demands of internal pressures on a case by case basis, without integrating these demands into identifying future placement resources development.

There were significant external events as well. The first was in January 1998 when the then Department of Family Services closed the Seven Oaks Youth Centre, which was a secure temporary receiving facility for children ages 12 to 18. The mixed gender facility had 22 bed spaces designated for youth in care of WCFS. Agency representatives from line staff to executive management have identified this external pressure as the one of the central reasons for the growth in the EAPD program. It is worth noting, however, that EAPD was in existence before the closure, and the impact of the closure on EAPD could have been no more than a total increase of 22 beds.

Changes to City of Winnipeg fire code regulations in 1998, and the agency's reaction to them, also had a strong impact on the department. The EAPD shelters were not then licensed under the Residential Care Licensing Branch, and so zoning, health and fire codes were not always followed. The fire code changed in 1998 to include child-care facilities (those with four or more beds) housing 0-10 year olds, and required the installation of inter-connected fire alarms and a second means of egress on each floor within the facility.[10] WCFS had been provided a three-year period to have their buildings brought to code in order to comply with licensing. Instead, WCFS made the decision to move from a four-bed model to a three-bed model to avoid the fire code regulations associated with licensing a child care facility.[11] The reduction in beds per facility then created the need to add additional three-bed facilities to accommodate the children already being served by EAPD.

When *The Child and Family Services Act* was amended in 1999, it required residential care licenses for "child care facilities for fewer than five children, that were operated by agencies where care and supervision was provided by persons employed by the agency".[12] Before the amendment, the EAPD shelters operated without licenses. The DFSH began discussions with WCFS in February 1999 to bring its facilities into compliance. This meant that the agency's previous attempts to circumvent zoning bylaws, health and fire code would now have to be addressed. The implementation of licensing did not have a direct impact upon the growth of EAPD, but it did divert the fiscal resources and management energies to ensure compliance with licensing regulations. Licensing was an external pressure that impacted on EAPD but this pressure appears to be a direct consequence of the operational decision-making process of WCFS management.

In May 2000, the OCA submitted its report to the DFSH regarding WCFS use of hotels for emergency child placements. The report focused on quality of care in the hotels over a five-year period, and identified gaps in service that contributed to the agency's ongoing hotel usage. The report found that hotels were used for placements, but the facility operation was unlicensed and unregulated. Of further concern, the report indicated that the use of hotels for emergency care did not address the best interest of children and alternate resources needed to be developed. The report also found a requirement for a more effective means of monitoring child placement data. The agency responded to the report in December 2000 with a copy of its Hotel

Replacement Plan, which specified steps to be taken to improve quality of child placement services, to expedite the placement process, and to develop appropriate resources for children and youth. The Hotel Replacement Plan promoted the expansion of EAPD shelter placement resources in co-operation with the DFSH.

The suggested expansion would serve the existing need within the shelters and provide the capacity to reduce hotel admissions. At this time the agency projected the annual need at 200 emergency receiving beds. An executive management member was aware of a stock of empty housing administered by the Manitoba Housing Authority, and suggested a co-operative partnership could benefit both organizations. WCFS determined areas where children lived before coming into care, and requested housing in those areas so it could try to place children in or close to their community. Manitoba Housing provided the agency with a list of available housing. The agency determined which homes were appropriate, and which were potentially unsafe. WCFS and the Manitoba Housing Authority, with the sanction of the then Minister of Family Services and Housing established a co-operative partnership, under which the agency identified suitable housing and Manitoba Housing completed the renovations required for the homes to meet licensing requirements. Unfortunately, of the 12 Manitoba Housing units chosen, only four homes were completely renovated and licensed before children were moved in. The remaining eight homes were occupied by children before the agency obtained licenses.

While EAPD was growing, the DFSH continued to require that EAPD shelters be licensed. DFSH staff reported to the OCA that "27 shelters were identified for licensing in 1999." By February 2001 the number of shelters waiting licensing was approximately 67. The agency was now attempting to create the required new resources while concurrently attempting to respond to demands for legislation compliance, and provision of quality care for the children in their short-term resources. At its peak in June 2001, EAPD contained 72 homes. Some of these shelters were opened by the agency as an attempt to avert hotel placement, but the request for licenses for some of them came to the DFSH after they were already in operation. The agency was creating resources in a reaction to placement needs and in response to internal and external pressures, with an apparent disregard for the licensing process.

Department of Family Services and Housing - Licensing Standards and Issues Impacting upon EAPD

The alteration of the original model from parent to shift staff had implications for the licensing of these facilities. Provincial regulations and standards would have required the agency to alter the license of the four-bed model from a licensed foster parent to a license required for a residential care facility. At the time, all adult and child residential care facilities were licensed under *The Social Service Administration Act*. This legislation ensured that any facility providing care for more than four children required a license from the licensing authority known as the Residential Care Licensing Branch. *The Social Service Administration Act* states in Regulation 484/88R (s.3)

> **"no person shall establish or operate a residential care facility for one to four children without a valid and subsisting letter of approval for that purpose."**

However, as the Residential Care Licensing Branch operated as a separate body from the DFSH, they would have relied upon letters of agreement for licensing proposals previously forwarded to DFSH. As WCFS initially operated EAPD on a four-bed foster model, they did not submit formal letters of licensing proposals to the DFSH when they supplemented foster parents *with shift staff. Consequently, the Residential Care Licensing Branch had no knowledge of the* existence of shift staff shelters, and did not request licensing compliance.

Once legislation changed in 1999 to include licensing of child care facilities under Child Protection Branch regulations under *The Child and Family Services Act*, the DFSH met with the agency to discuss the new requirements. Under the new regulations, EAPD shelters were categorized as specialized treatment units, as agency staff provide care and supervision to fewer than five children. The new regulations indicated that specialized treatment unit, or similar facilities, must comply with the criteria described under an application for a licence[13] and that the Provincial Director would designate the duration of the license and the number, ages and sex of the children that could be served in the facility. Representatives of the DFSH reported to the OCA that WCFS did provide a few applications for license, but cautioned that within the licensing process there was a period when licensing had to 'play catch up' to implement the process for existing facilities. The focus of the DFSH was to have the facilities licensed, therefore they initially did not ask for proposals for those shelters already in existence. However, some of the facilities were opened by the agency before it provided the DFSH with an application for license. The proposals submitted under the application process were brief and some were inadequate in terms of function they would be serving. "EAPD was kind of an entity unto its own. WCFS were attempting to reduce hotel usage, and did not always follow the licensing process".[14]

The regulations outline minimum staffing qualifications[15] as well as guidelines of staff functions, required areas of care and supervision, dietary/food service, and domestic support/facility maintenance.[16] More importantly, standards and regulations indicated that "all residential treatment services should have common characteristics"[17] and the facility is required to have written statements of the program and services offered, the goals and objectives of the program, and make them accessible as required (Child Care Facilities Standards Manual, p. 33). The individual shelters were considered to be fulfilling a global service function of the EAPD program, providing one form of service (emergency receiving assessment) in a variety of locations. Therefore, the DFSH did not request a specific program statement for each shelter from WCFS. There was a general understanding and a general acceptance that EAPD service had a more blanket concept in their approach to service.[18]

While the basic concept of the emergency receiving assessment function was clear to the DFSH, the identified target population who would receive this service was less clearly defined. The intent was to provide short- term care with assessment for an identified population of children ages 0 to 17 who required out-of-home care. The difficulty encountered by the DFSH was that licensing EAPD created a constant struggle to ensure children's needs were being met within a facility providing short-term emergency care to a wide range of children with varying needs at the same time. EAPD was licensed for children 0 to 11 and youth 12 to 17 and the intent for both age groups was to provide care in a short-term emergency receiving and assessment facility, not to provide long-term care and treatment. Although EAPD had program statements that confirm this intent, at times the program fell short of this goal.[19]

Further licensing requirements that impacted upon EAPD covered the necessary qualifications of staff. Although many of the staff had previous experience, met educational requirements, or had long-term employment with the agency as childcare workers, a significant number did not have updated training in First Aid or CPR, and some had no training in those areas at all. The DFSH provided a three-year timeframe for the agency to have all required staffing qualifications up to date.

Another problem was that many EAPD homes did not meet zoning requirements or health and fire code regulations. As such, these facilities were not eligible for licensing or continued operation for child care. WCFS owned many of these properties, and attempted to convert them into designated professional foster parent homes, licensed under foster care regulations. However, WCFS could not find professional foster parents for all the homes, and continued to operate as an unlicensed child care facilities until the children residing in them moved on to alternate placements. In some cases, children resided in these unlicensed facilities for over two years.

While licensing standards and regulations have addressed the placement of children in unregulated, unlicensed care, the current standards do not adequately address the uniqueness of EAPD. The EAPD care facilities are not able to ensure consistency in adhering to a program description or the program statements reflected in standards due to the continual changes in the population identified within each shelter. The designation of a license for ages 0-11 and/or 12-17 allows for a mix of children at various developmental stages notwithstanding their individual needs and circumstances. Although regulations allow for EAPD to apply for a variance to give them flexibility in moving beyond these designated age ranges, these variances are typically used to accommodate sibling groups.

The Program Model

The EAPD has neither adopted nor developed a program model that depicts the current goals, objectives and functions of the program as it currently exists. The original EAPD model was an adaptation of the Northwest foster parent model with defined goals, objectives, principles and values. However, the shelter system has evolved over the last six years, and no longer employs this model.

It would appear that the program's current intent is to provide emergency placement, assessment, and to provide stability for children and youth in a home-like environment when alternate, out of home care resources are unavailable. The EAPD Home Manual provides an introductory statement that the OCA believes is intended to be the program statement:

> ***"Emergency homes are designed to provide short term transitional care to children and adolescents. Our programs are designed to provide stability, quality care, and functional assessments to assist in long-term planning Children placed in our programs have often come from turbulent environments where they have witnessed or endured abuse and neglect, and require sensitivity, compassion and quality care regardless of the length of stay. Given the nature of the care required, it is important that sound, consistent structure and routine are in place for the children and the care-givers who work with them."***

In interviews, staff agreed the paragraph that follows could serve as the EAPD mission statement, although it is not formally identified as such:

> ***"The Emergency Assessment Placement Department of Winnipeg Child and Family Services is dedicated to provide superior transitional care and protection to children. We ensure that the unique needs of the children are met in a safe, nurturing environment through assessment planning and innovative programming."***

According to staff interviews and focus groups, the most commonly reported goal of the EAPD program is to provide a safe and nurturing environment for children residing in emergency care. The staff also reported that the program achieves this goal through ensuring a consistent daily routine, provision of recreational opportunities and establishing community connectedness. The OCA, however, was not able to find any definitive statement of goals or objectives within the description of the program, or within interviews conducted with senior management personnel charged with administration of the program.

The EAPD does not employ a program model containing specified goals that are translated into programmatic objectives and intended outcomes. Further, the program has never been evaluated by the agency. EAPD coordinators have reported that initially the program was designed around the needs of the home, and the staff complement was tailored around the needs of the child. However, as internal and external demands were placed upon EAPD, the program was required to be more flexible, less specialized with emphasis on maximizing the use of emergency care beds. As such, the initial vision of EAPD was lost. EAPD has been described by line staff, coordinators, and management, to the OCA, as

> **"the program that can not say 'No'; it is everything to every child ages 0-17 requiring placement."**

Policy and Procedures

As EAPD developed, so too did the need for administrative guidelines that would govern the program. As the model shifted from foster care to staff care, it became apparent there would be a greater need to standardize practice (child management and administrative rules) to ensure consistency of care and operation of the facilities. The EAPD program began to develop administrative policies and practice procedures when the program was still in its infancy in 1997-98. Given that the original model was based on a foster care model, resulting policies and procedures have been "piggy-backed" onto foster care licensing regulations and standards and the provincial foster home manual.[20]

As the use of staff increased it soon became apparent that the programs, policies and procedures developed for foster parents did not "fit" with staff working shifts. Further as the program opened to accept children from all other service areas it became apparent that the policies and procedures based on Northwest and Central foster care programs did not always fit with Southwest or East Areas. The EAPD admittance criterion was to accept any child or youth requiring emergency care. The program, under a foster care model, allowed the agency more opportunity to restrict admissions, often based on foster caregivers' skills, abilities and expressed preference. Movement to a shift care model placed pressure on the program to "accept any and all" children and youth who required placement.[21] High-needs and difficult-to-place children and youth entered into the shelter system. Problems soon emerged.

To address these problems, EAPD began to augment their policies outlining child management and administrative practices. Coinciding with the internal needs for policy development were external pressures to meet legislative requirements. While working toward licensing, the agency was also opening new shelters to meet the placement needs of children, and as a result was always in a position of playing 'catch up' to licensing. By March 2002, a shelter coordinator was assigned to manage the agency's licensing efforts. In their attempt to meet licensing requirements, the EAPD amalgamated the existing policies and procedures and created additional policies and procedures that they believed were reflective of licensing requirements and ultimately a shift staff model of care. The EAPD Home Manual was created.

What the Literature Tells Us

The literature in the area of emergency shelter care is limited, although some form of emergency care exists in each province. The difficulty in comparing data and literature is that each province varies in its description of purpose, function and program within emergency alternate care. The literature that is available is limited in its applications to the EAPD concept of emergency care. This is likely due to the fact that the EAPD concept of shelter care is a relatively new phenomenon. There was no model or provision for shelter care within Manitoba provincial licensing until 1999.

With the changes in legislation in 1999, the Child Care Facilities licensing regulations and standards included a facility description that would enable the licensing of EAPD shelters. Although the Child Care Facilities Licensing standards and regulations provide a description for temporary shelters, EAPD is not classified under this category. EAPD falls under a separate licensing description of residential care. The description depicts EAPD as a specialized treatment unit or similar facility, operated by agencies which house fewer than five children, where care and supervision is provided by persons employed by the agency. Further, each licensed facility must contain certain characteristics as outlined in the program statement of the Residential Care standards and regulations.[22]

Literature in the area is available through the Child Welfare League of America Standards of Emergency Shelter Care. The standards indicate that the purpose of an emergency shelter is to provide, for a maximum of 30 days, protection and safety to children in an environment where the needed services to crisis resolution can't be delivered in the family or foster home. The shelter provides basic necessities for children in emergency care. This form of emergency care provides an intake assessment within the first eight hours, and crisis counseling when necessary.[23]

Given the shortage of literature and the absence of a program model, we felt that a definition and qualifying assumptions about the program's purpose and function needed to be created before it could be effectively reviewed. The OCA developed a definition of shelter and assumptions based upon current provincial standards, Professional Standards of Excellence (CWLA), and a literature review. The representatives of the shelter review team agreed upon, and approved this definition at the outset of the review.

Definition of Shelter

A licensed residential care facility that is community based and home-like for children and youth within the CFS system. It is responsive to an emergency/crisis situation that requires a safe and protective care alternative for a limited period of time. This is a developmentally appropriate group living environment that provides supervision, structure, support, and programming which is child centred and delivered in a flexible manner to meet the needs of children and youth.

Assumptions of Shelter Care

1. Based upon "Best Interests."
2. It provides protective substitute care for the child.
3. Placement in shelter is of benefit to the child.
4. Provides basic necessities - food shelter, clothing medical, educational and recreation.

5. Staffed with qualified, competent, trained care providers.
6. Provides basic assessment of child's needs.
7. Transitional to other care - foster, independent living, kinship, other residential care or home.
8. Time limited – 60 days.
9. Home setting is conducive to promoting healthy growth and development of child.
10. Environment and program of shelter is conducive to ensuring connectedness to family and identified community.
11. Complies with minimum standards and regulations as set out in the CFS act.
12. Shelters exist within programmatic boundaries, which defines purpose, policy, procedures, stated goals, objectives and outcomes.
13. Program is accountable to an authority, community and child.
14. Community based which ensures access and linkages to schools, recreation and resources.
15. Staff-child ratios are flexible and appropriate at all times to meet individual child, and group need and situation.

PART 4: WHAT SHOULD HAVE BEEN KNOWN AND WHAT WE FOUND OUT

National Overview

Throughout our review, WCFS cited the increased needs of children and youth coming into care as having an impact on their ability to provide care. It was the explanation and often justification for the expansion of the shelter system. Generally, though this statement may be accurate it would appear that the agency struggled to consistently gather trend data or child-specific data that would assist the agency in justifying the expansion of the shelter system or evaluating its effectiveness.

Without uniformly knowing the population to be served, and the needs of that population, the agency could not fully respond to that population. The agency was moving from one crisis to another and responding to placement needs on a case-by-case basis. As one senior manager noted, "it was crisis management without management realizing there was a crisis." While case-specific issues were being addressed, at least in the short term, little was being done to track or forecast the larger perspective.

In fairness to the agency, WCFS was not alone in failing to get a handle on this issue. Until recently, little was known about child maltreatment from a national perspective. The 2001 Canadian Incidence study[1] (CIS) was the first nation-wide study to examine the incidence of child maltreatment and the characteristics of children and families served by the Canadian child welfare services. The CIS found that:

- 135,573 child maltreatment investigations were carried out across Canada resulting in an incident rate of 21.52 investigations per 1,000 children (under age 16).
- Forty-five per cent of investigations were substantiated; 33 per cent were unsubstantiated and 22 per cent remained suspected.[2]
- Neglect was the primary category of maltreatment for 40 per cent of all investigated cases; 43 per cent of these investigations were substantiated. Physical abuse made up 31 per cent of total investigations, 34 per cent of which were substantiated. Emotional maltreatment made up 19 per cent of total investigations, 54 per cent of which were substantiated; sexual abuse made up 10 per cent of the total investigations of which 38 per cent were substantiated.
- After the initial investigation 64 per cent of cases were closed and 34 per cent remained open.
- Thirty-six per cent of all investigations involved children from families that received social assistance or some other form of benefits. An additional 10 per cent involved children whose families relied on part time employment/multiple jobs or seasonal employment.
- Forty-six per cent of the investigations were conducted in homes headed by a lone parent: 40 per cent by a female parent and six per cent by a male. Substantiation rates varied little (46 per cent two parent home and 40 per cent single female parent home) when household structure was compared.
- Fifty-seven per cent of investigations involved children living in rental accommodations (47 per cent in private market rentals and 10 per cent in public housing).

- Thirty-seven per cent of investigations occurred in families where housing was described as unsafe.
- Family stressors were identified in 73 per cent of investigations (alcohol abuse 34 per cent; child history of abuse 31 per cent; lack of social support 29 per cent; mental health problems 24 per cent and spousal violence 23 per cent).[3]
- Eight per cent of investigations resulted in a child being placed into child welfare care. Placements were not required for 84 per cent of child maltreatment investigations.
- Overall, "placement rates increase with the frequency and duration of the maltreatment, the level of physical harm, the level of emotional harm, and previous reports" of child maltreatment investigations.[4] (2003:39).
- Placement rates are higher for adolescents ages 12 –15 (13 per cent for males and 11 per cent for females) than for younger children. Children ages 0 to 3 (females nine per cent, males eight per cent) are the next likely age group to be placed.[5]
- Children and youth identified as possessing child behavioral or health concerns such as substance abuse related birth defect (28 per cent); self harming behavior (18 per cent); psychiatric disorders (16 per cent) have higher placement rates.[6]
- Adolescents are rarely removed from their homes for child protection reasons. The decision to remove is more likely if there are identified behavioral issues including criminal involvement (26 per cent), running away (19 per cent) and violence towards other (17 per cent).[7]

It is also clearly documented that in Canada, and more specifically in Manitoba, aboriginal children and youth are over represented in the child in care population. Generally aboriginal children and youth are at higher risk than their non-aboriginal counterparts of coming to the attention of child and family service agencies. As found in the First Nations Child and Family Services Joint National Policy Review (June 2000):[8]

- Fifty per cent of First Nations children living on and off reserve live in poverty.
- More than half (52 per cent) of First Nation households live in homes that fall below one or more of the basic Canadian Housing standards as compared to 32 per cent for non-first nation households.
- Compared to non-aboriginal counterparts, First Nations youth are 1.6 times more likely to report living in a lone parent family and 1.4 times more likely to report living in a non family setting.
- First Nations children are at a higher risk for health related issues than non- First Nations children. The incident rate of disability among aboriginal youth is 1.7 times higher than the general population. Aboriginal youth are at elevated risk of suffering from a physical, developmental or learning disability.
- Suicide rates of registered Aboriginal youth (ages 15 to 24) are eight times higher than the national rates for females and five times higher for males.
- In 1996, more than 10 per cent of Aboriginal children (ages 0-14) were not living with their parents.

Children do enter care due to parental incapacity but that incapacity has been built often on a foundation of "child, parent, family, community and societal forces leading to the breakdown of families".[9] Cameron, in his review of 380 parents involved with a CAS agency in Ontario, found that the majority of families were under consistent and constant pressure. Many lived in poverty, were socially isolated and experienced high levels of stress within the home. Parents had little access to relief or respite. Many of the children experienced difficulties in school or in the community, and many parents were coping with physical and mental health problems.[10]

In another review of 15 mothers receiving services, one-third of whom had a child removed from their care, Cameron again found that a majority of the families lived in poverty. Sixty per cent of the mothers worked outside the home for low pay. The majority of them had the sole responsibility to care for their children. Themes common to these families were family alcoholism, parental history of childhood sexual abuse and child maltreatment, domestic violence, social isolation and involvement with social services. However, Cameron also noted strength, resiliency and resourcefulness among these families.[11]

It is now generally accepted that poverty and inadequate housing are associated with increased risk for families and their children and youth. "The general impact of poverty on the well-being of children sets the stage for most children, youth and families in the child welfare system".[12] As stated by McKenzie and Trocme, gender may also be an "influential determinate" as there appears to be an over representation of women, particularly those who are single parents and poor, who receive services.[13] Gender also interacts with cultural factors in explaining the over representation of aboriginal children. However, as pointed out by Mackenzie and Trocme, more significantly the effects of colonization have contributed and continue to contribute to the disproportionate number of aboriginal families, children and youth involved in the child welfare system.[14]

Literature would suggest that these children have been adversely affected by poverty, substandard housing, "poor nutrition and a lack of a psychosocial support" which places them at greater risk than children in the general population. Their pre-care experience (abuse, neglect, maltreatment, poverty, violence etc) may contribute to their increased risk for ill health, lack of educational attainment, increased risk for developmental or mental health issues.[15] Canadian research cites increasing prevalence of emotional and behavioral problems for children in foster care.[16] Children considered to be special needs[17] are entering into our system at alarming rates. Though five to seven per cent of children and youth in Canada have some form of disability, the Canadian Association of Community Living estimate that among 60 per cent of children in care have some form of disability.[18] It is believed that children and youth pre-natally exposed to substances also make up a large portion of children in care. In 2001, in Alberta it was reported that 50 per cent of the children in care were likely suffering FAS/FAE.[19]

This information tells us that the identified factors that contribute to a child coming into care extend beyond those that a child welfare agency can singularly address. The agency should, however, take them into account when assessing, developing or enhancing the shelter system or for that matter any of their programs. As suggested by Cameron (2003), "if we are to turn our history around about poor child welfare outcome, our policies and practice need to be grounded in credible information about these families' lives, as well as in reasonable understandings of the pressures causing them to break down".[20] It is essential that these factors are tracked and monitored in order to develop services, such as a shelter system, that will contribute to positive outcome for children and youth and their families.

A Demographic Overview of the Children and Youth

The Origins of the Data:

The OCA requested demographic data over a five-year (1998 to 2003 fiscal years) period. We requested variables such as age, gender, aboriginal status, legal status, number of placements, prior placements, discharge placements etc. Lacking one central data base, the agency was unable to provide all the information for the time period requested. The agency operates multiple data base systems to track these and other child case specific variables. The agency operates CFSIS as their case management database, they have a separate accounting data system and they also recently introduced the STEP[21] data base to track children in short term emergency care. The agency's different programs often can collect information for their internal program need. For example the placement desk will track open foster beds, number of beds used and number of children requiring placement. Someone else in the foster care program will track number of foster home applications, number of homes licensed and number of place-of-safety homes.

The agency could not provide information in all fields requested. Well over one third of the child or youth information provided was missing some data. For example WCFS could not with any certainty track aboriginal status over the five years requested. The OCA and the DFSH reviewed all files with missing data then filled in the missing data with information recorded by WCFS staff on CFSIS. If there was no information the field was left blank. Any file that was classified, as a "confidential file", which could include adoption files or closed files as the youth turned 18 during the five years reviewed, were not opened.

Data analysis included all children and youth placed in the EAPD system which included the shelters, and the, ERPH-IPP (Emergency receiving homes) and mom and babe shelters between 1998 and 2003. Hotel days were not reviewed. Over the five years reviewed the OCA determined that 3,085 children and youth were placed in the EAPD system. As can be seen in Table 1, 75 per cent of children and youth or 2,318 were placed in the shelters over the five years reviewed.

Table 1

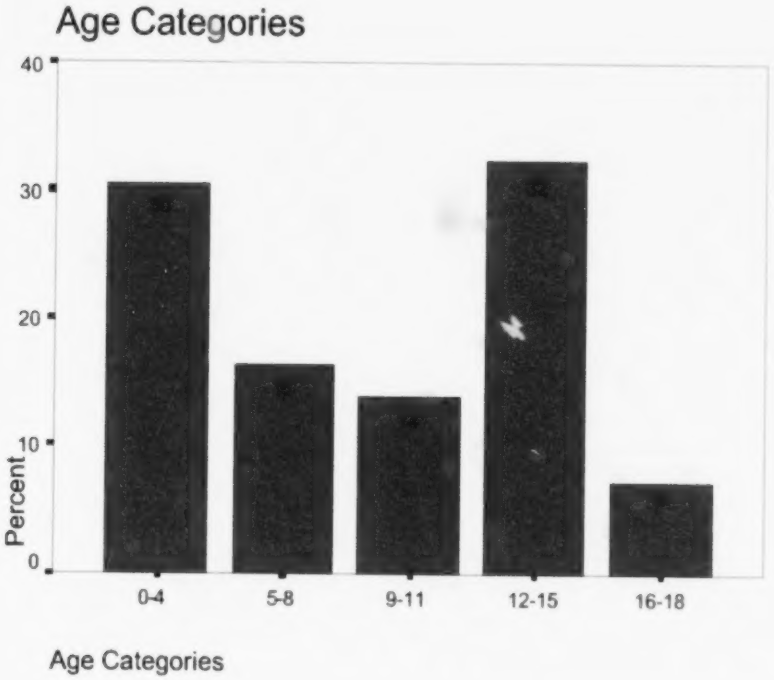
Shelter or Other Placement

	Frequency	Percent
Shelter	2318	75.1
Other	767	24.9
Total	3085	100.0

The average number of days a child or youth was placed in emergency care was calculated for both the shelter placements and all emergency placements. The average or mean number of days a child or youth spent in the shelters[22] (over the five years reviewed) was 44 days. The average or mean number of days children or youth spent in emergency placements[23] was 41 days.

Age: The age of children and youth, at the point of their first admission to the EAPD system, varied from under one year to a maximum of 18. The most frequently recorded age was 13 years, with a mean age of 8.6 years. Fifty per cent of children placed were nine years or younger, 25 per cent of children placed were three years or younger. The most infrequently reported placed age group was youth between the ages of 16 to 18.

Figure 1



As can be seen in Figure 1 the EAPD system inclusive of the shelters served younger children: Sixty per cent were 11 years or younger.

Age was divided into two categories, young child (0-11years) and adolescent (12-18 years). Young children comprised 60 per cent of the children and youth and adolescents accounted for 40 per cent.

Gender: Of the children and youth placed in the EAPD system 48 per cent were female and 52 per cent were male. As can be seen in Figure 2 gender and age of child was cross-tabulated and graphed. Of the female children and youth 27 per cent were 0-4 years of age and 37 per cent were 12 to 15 years of age. Thirty-three per cent of males were ages 0 to 4 and 28 per cent were ages 12 to 15. Of note is that there were a higher percentage of female youth ages 12 to 18 being placed in the EAPD program.

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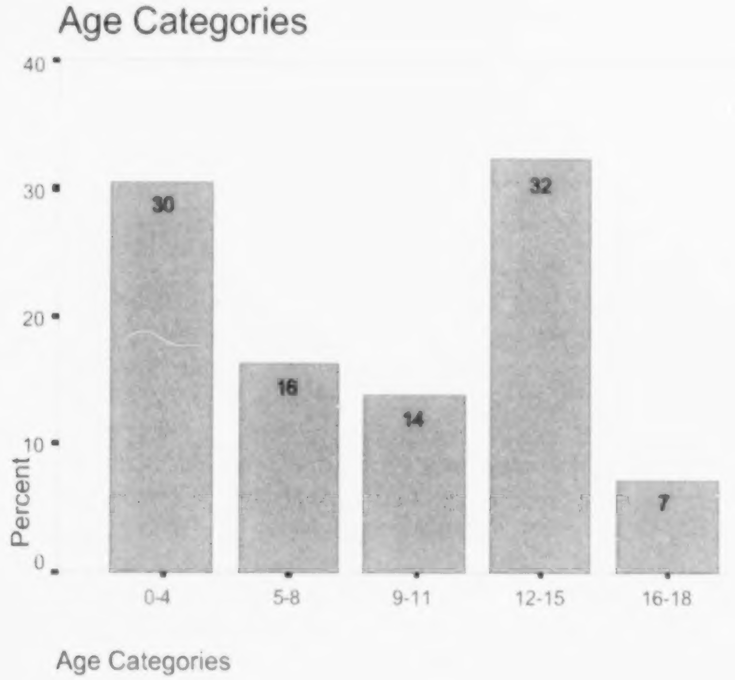

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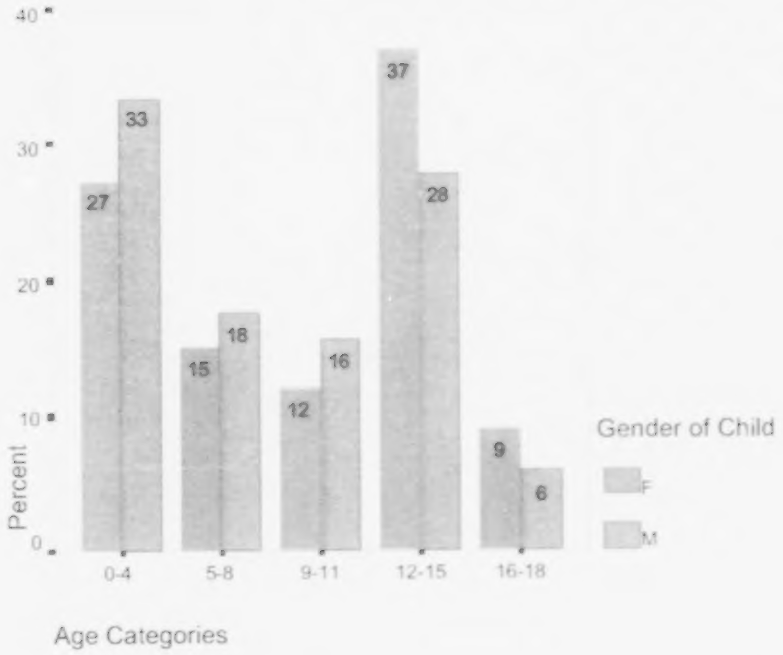

Age and Gender in Shelters: When one looks at age and gender of a child and their placement in the shelters, more young (ages 0-11) male children than female children were placed in both the shelters and other EAPD placements. Adolescents (ages 12-18) in the shelters were evenly divided between male and female (See Table 2). However, more female adolescents (61 per cent) are placed in 'other' emergency placements than were males (39 per cent).

Table 2

Gender	Age							
	Young Child				Adolescent			
	Shelter		Other		Shelter		Other	
	Count	%	Count	%	Count	%	Count	%
Female	760	43.4%	47	39.5%	284	50.0%	395	61.0%
Male	990	56.6%	72	60.5%	284	50.0%	253	39.0%

Legal Status: Children and youth can enter the EAPD system from their homes or community or from other agency care arrangements. Once a child or youth enters into care the agency can apprehend a child or enter into a Voluntary Placement Agreement (VPA) with the parents and or guardian. Parents can also surrender guardianship (VSG) of a child to the agency. Children and youth that are already in care under a Temporary Order as Temporary Wards (TW) or Permanent Order as Permanent Wards (PW) can also enter the EAPD system. Children and youth under the care and supervision of another agency can also be placed in the EAPD system: WCFS staff cares for these children but their case is managed by another CFS agency (WOA). Their legal status is recorded in the other agency's file. Children in care of the agency require a

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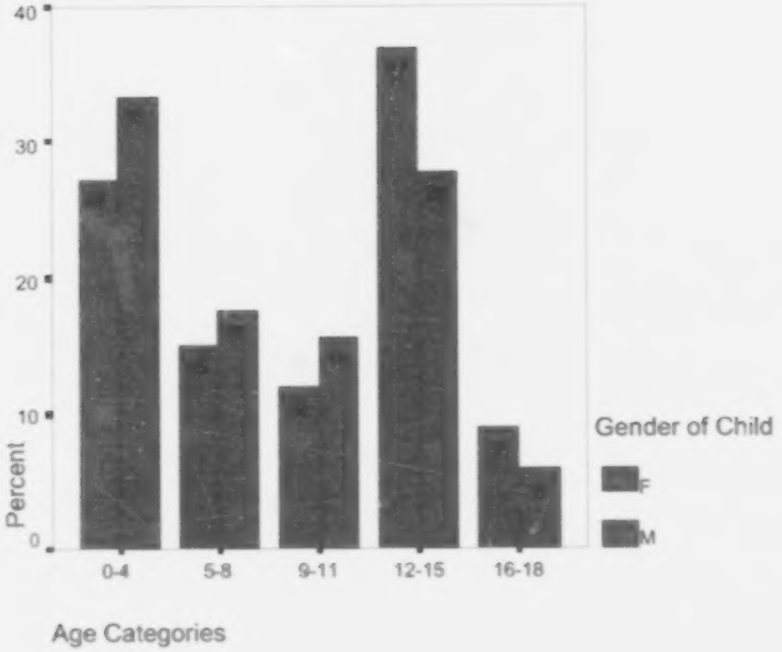

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Legal status was recorded in five categories (Table 3). 'Other' includes VSG and WOA. The majority of children and youths' (67.8 per cent) legal status upon admission into the EAPD system was recorded as an apprehension.

Table 3

Legal Status	Frequency	Percent
Apprehension	2091	67.8
Permanent Order	284	9.2
Temporary Order	146	4.7
V.P.A.	547	17.7
Other	17	.6
Total	3085	100.0

Legal Status by Age: Legal status was compared to age of child at admission to EAPD system. The legal status was recorded as apprehension for the majority (81 per cent) of children ages 0 to 11, whereas only 47 per cent of adolescents (ages 12 to 18) legal status were recorded as apprehension. As well, 31 per cent of adolescents were recorded as being under a VPA as compared to nine per cent of younger children (See Table 4).

Table 4

	Young Child		Adolescent	
Legal Status	Count	%	Count	%
Apprehension	1515	81.1%	576	47.4%
Permanent Ward	70	3.7%	214	17.6%
Temporary Ward	99	5.3%	47	3.9%
V.P.A.	173	9.3%	374	30.8%
Other	12	.6%	5	.4%

Shelter placement by age and legal status: Legal status was cross-tabulated with age of child and shelter placement. As can be seen in Table 5, of the young children (ages 0-11) placed in the shelters, 81 per cent were under apprehension and only nine per cent were under a VPA. This differed somewhat with young children placed in 'other' placements; 78 per cent were under apprehension and 14 per cent were under a VPA. The frequencies of legal status also varied for adolescents (ages 12-18) placed in the shelters as compared to other placements. While the VPA status of adolescents, placed in the shelters or other placements, were relatively equal, a higher percentage (50.5 per cent) of adolescents under apprehension were placed in other placements. Of interest to note is that 22 per cent of adolescents placed in the shelters were permanent wards of the agency.

Table 5

Legal Status	Young Child				Adolescent			
	Shelter		Other		Shelter		Other	
	Count	%	Count	%	Count	%	Count	%
Apprehension	1422	81.3%	93	78.2%	249	43.8%	327	50.5%
Permanent Ward	62	3.5%	8	6.7%	125	22.0%	89	13.7%
Temporary Ward	98	5.6%	1	.8%	21	3.7%	26	4.0%
V.P.A.	156	8.9%	17	14.3%	171	30.1%	203	31.3%
Other	12	.7%			2	.4%	3	.5%

Placement Type Prior to First Admission in EAPD: Given that the EAPD system was to provide emergency short-term care for children and youth as well as to create an alternative to the agency's reliance on hotel placements, the OCA was interested in where the children and youth were residing before their first EAPD placement. Coupled with the agency's intent to provide emergency short-term care, the OCA heard from agency staff that the shelters were absorbing children and youth from other care facilities or foster homes. The OCA wanted to determine prior placement of children and youth to provide some insight as to whether the EAPD system was serving the community or serving the childcare system.

Prior Placements were divided into six categories. The variable EAPD in this section refers to children and youth placed in hotels. Foster care included all paid care arrangements provided in a family setting licensed as foster homes (foster homes, kinship homes, professional parents, specialized foster care inclusive of emergency receiving foster homes). Community included all family settings, not licensed and not paid (parental, adoptive homes, non-pay care). Group care included all residential care (CFS care, Corrections, group homes, health settings, treatment settings). As can be seen in Table 6 the majority of children and youth (51.5 per cent) were living in some form of foster care prior to their admission into the EAPD setting. A significant number of children and youth (28.1 per cent) were placed in hotels before their admission into the shelters. Only 10.3 per cent of the children and youth entered the EAPD system from the community and their familial homes (biological, kinship or adoptive).

Table 6

Placement Prior to Admission

	Frequency	Percent
AWOL	5	.2
EAPD	867	28.1
Foster Care	1588	51.5
Community	318	10.3
Residential	262	8.5
CSU	1	.0
Total	3041	98.6
Missing System	44	1.4
Total	3085	100.0

The figures suggest that the EAPD system has been successful in removing children from hotels, however, it is also acting as a placement resource to the foster care system. Emergency Receiving Foster Homes (ERFH) and staffed foster homes, which normally are a part of the agency's larger emergency care system, were included in the foster care category. One hundred and eighty four or six per cent of children and youth placed in shelters came from ERFH homes (n=184 or six per cent ERFH and n=691 or 22.4 per cent FH-Staffed). Six hundred and ninety-one or 22 per cent had prior placements recorded as staffed foster homes. Though the shelter system appeared to be successful in removing children and youth from the hotels they also appeared to be recycling children inside the emergency care system from hotel to shelter and from shift staff foster homes[24] or ERFH to shelters. Overall it would appear the shelter system was a resource to support and augment the existing CFS substitute care system.

Prior Placement by Age: The OCA also wanted to determine the age of the child or youth and compare that to their prior placement. Given the high number of younger children in shelter care the OCA initially thought that the younger children ages 0 to 11 were coming primarily from the community and shelter care was their first placement. Conversely the OCA thought that adolescents were coming from residential care. As can be seen in Table 7 of the 1,588 children and youth coming from foster care, younger children (ages 0 to 11) represent a slight majority (54 per cent). When the variable age is divided into five categories (0-4; 5-8; 9-11; 12-5; and 16-18) adolescents ages 12 to 15 appear to be entering into the shelters from foster care and the community more often than younger children. However, there was also a greater frequency of younger children coming from hotels and residential care. The residential care category also included health care setting (hospitals). A number of children ages 0 to 4 were recorded as coming from health care settings and likely reflects younger children entering care from a hospital setting. When hospital care settings are removed, then adolescents ages 12-15 are coming from residential care at a higher frequency compared with younger children (ages 0 to 4). However when the age variable is divided into two categories (0-11 and 12-18) children ages 0 to 11 are entering shelter from foster care slightly more often than adolescent ages 12 to 18.

Table 7

Placement Prior to Admission	Age Categories									
	0-4		5-8		9-11		12-15		16-18	
	Count	%	Count	%	Count	%	Count	%	Count	%
AWOL							3	.3%	2	.9%
EAPD	369	39.4%	168	33.6%	153	36.0%	159	16.5%	18	8.3%
Foster Care	396	42.3%	261	52.2%	201	47.3%	591	61.5%	139	63.8%
Community	63	6.7%	62	12.4%	56	13.2%	116	12.1%	21	9.6%
Residential	109	11.6%	9	1.8%	15	3.5%	91	9.5%	38	17.4%
CSU							1	.1%		

Legal Status at First Shelter Admission: Given the number of Permanent (PW) and Temporary (TW) Wards placed in the emergency care system the OCA wanted to determine their legal status prior to their first admission into the shelters. As can be seen in Table 8 67.5 per cent of PW are entering into shelter from the foster care system. [25] A significant number of TW are entering in from the hotels (36.1 per cent) or from foster care (38.2 per cent). Over half of the children and youth under a VPA (53.2 per cent) are entering from foster care. These numbers again suggest that the EAPD system is serving primarily the foster care system and dealing with children already known to the agency and in agency care prior to admission into the shelters.

Table 8

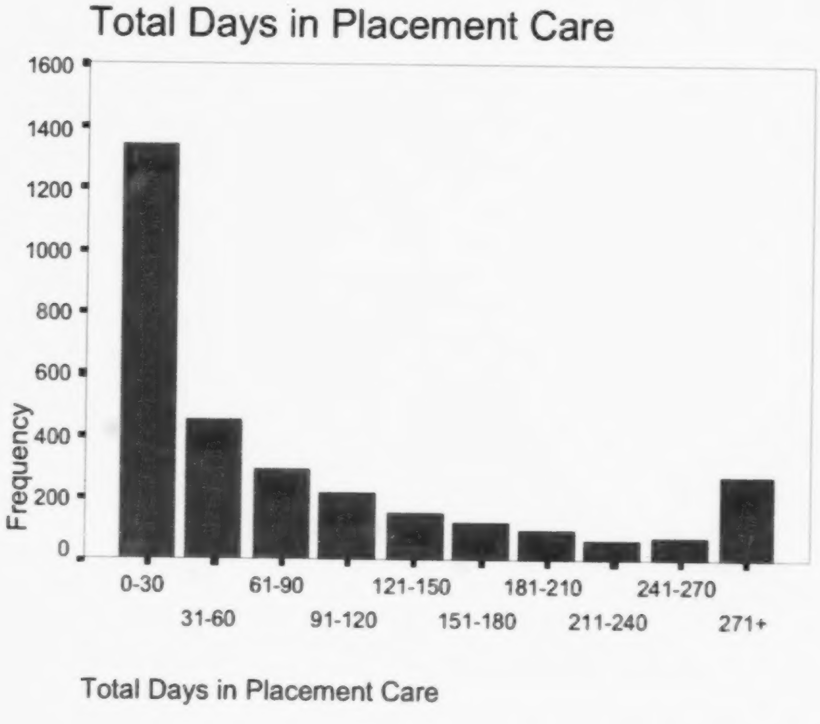
Placement Prior to Admission	**Legal Status at First Shelter Admission**													
	Apprehension		**Order of Sup.**		**Permanent**		**Temporary**		**V.P.A.**		**V.S.G.**		**W.O.A. 5**	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
AWOL	2	.1%			1	.4%			2	.4%				
EAPD	664	32.0%	1	33.3%	35	12.4%	52	36.1%	115	21.9%				
Foster Care	1054	50.8%			191	67.5%	55	38.2%	279	53.2%			9	75.0%
Community	208	10.0%	1	33.3%	33	11.7%	20	13.9%	53	10.1%			3	25.0%
Residential	145	7.0%	1	33.3%	23	8.1%	17	11.8%	75	14.3%	1	100.0%		
CSU	1	.0%												

Days in care EAPD/Days in shelter care: The OCA was interested in how many days in care children were placed in both the EAPD system and specific to the shelters. The assumption of the OCA was as per the CWLA standards for emergency care, that children and youth experience a maximum length of stay of 30 days. Under special circumstance an extension of an additional 30 days can be granted, however the total days allowable would not exceed 60 days. The total number of placement days (EAPD) range from less than one day to a maximum of 1,450 days. The mean number of days in EAPD placements was 95. However 60 per cent of children and youth had a total number of 66 or fewer placement days, 75 per cent of children and youth had 122 or fewer total days in placement. Ninety per cent of the children and youth had 254 or fewer total days in placement.

There are currently no standards in Manitoba which set a maximum number of days a child or youth can stay in emergency care. Though the majority of children experience 66 or fewer days, which does partially meet CWLA standards, 40 per cent remained longer.

Due to the frequency of situations where children and youth remain in the EAPD system longer than recommended under recognized international standards, total days in placements was divided into 30-day categories. Nearly 60 per cent of the children and youth exited emergency placements within 60 days. As can be seen in Figure 3, as the days in care increased the number of days in care for children and youth decreased with the exception of children and youth remaining for 271 days or longer.

Figure 3



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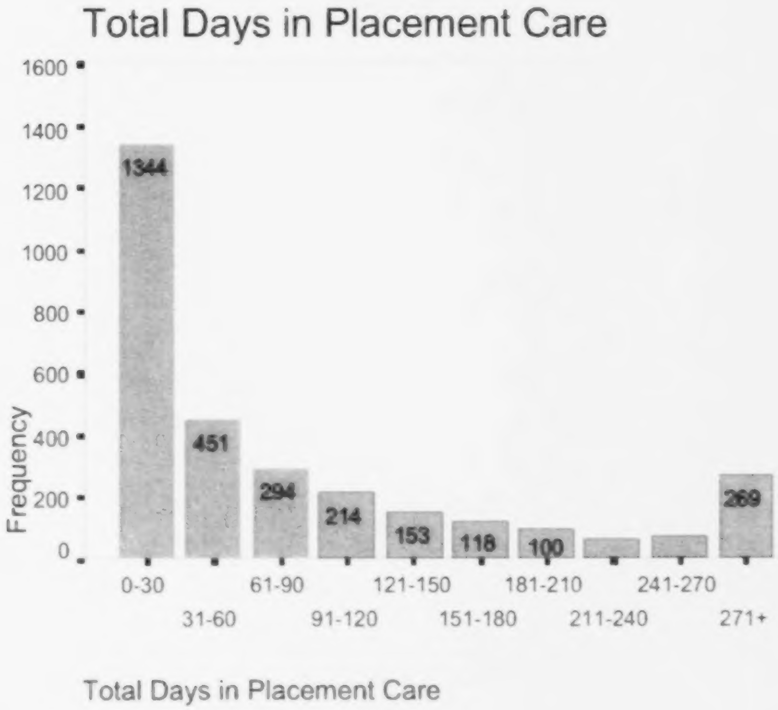

The distribution of days in shelter care was comparable to the total days in placement. Shelter days were broken down further into 14-day blocks and coded into seven categories: 1 to 14, 15 to 28, 29 to 42, 43-56, 5 to 70, 71 to 90 and 91or more days. As can be seen in Figure 4, 789 or 34 per cent of children and youth remained in the shelters for 1 to 14 days. Again as in total days in placement approximately 60 per cent of children and youth were exiting the shelters within 60 days. The most infrequently reported group for days in care was 56 to 70 days. Similar to the total placement days findings, as the number of shelter days increased, the number of children and youth remaining in shelters decreased, with the exception of children and youth recording a total of 91 or more days.

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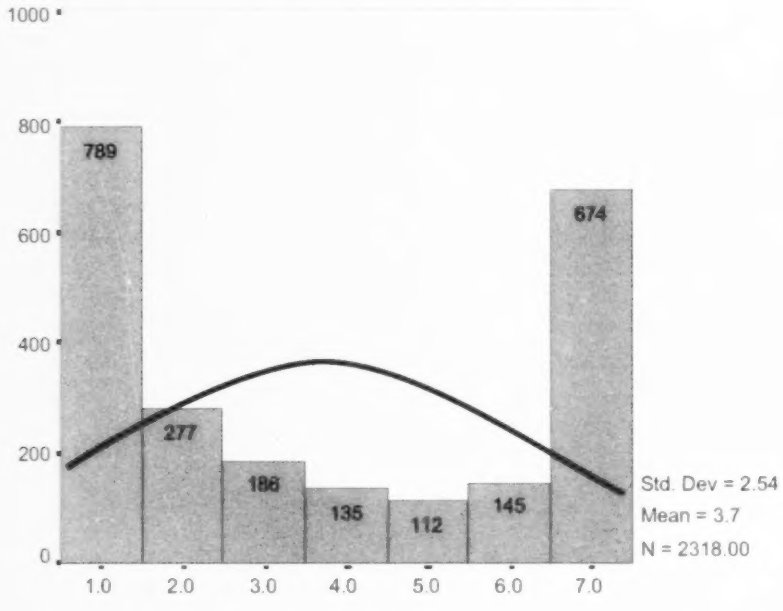

Total days in shelters (categories)

Though it is admirable that the agency was removing children and youth from the emergency care inclusive of shelters within a 60-day period, standards would dictate that children and youth should not remain longer than 30 days and only in special circumstances be extended to 60 days. The OCA cannot comment if these children and youth case circumstances would have warranted an additional 30 days.

Days in EAPD Care/Age: The OCA wanted to determine the age of the child or youth as compared to their stay in emergency care. It was hoped, particularly in the shelter system, that younger children would be moved to alternative care as quickly as possible. Conversely it was expected that difficult to resource adolescents would likely stay longer. The majority of children and youth do exit the shelter system within 30 to 60 days.

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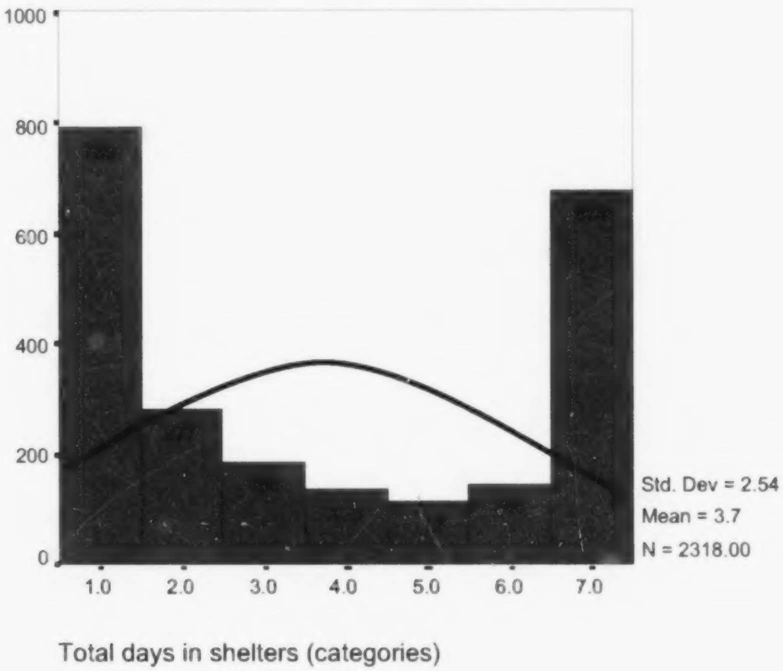

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The data, however, did demonstrate that there is an increase in frequencies for the higher number of placement days across all age groups throughout the EAPD system inclusive of shelters. Of concern is the number of very young children ages 0 to 4 and young adolescents ages 12 to 15 who appear to have experience lengthy stays. As can be seen in Table 9 children (ages 0 to 4) and youth (ages 12 to15) appear to be staying longer than other age children (ages 5 to 8; 9 to 11) and youth (ages 16 to 18). For example, children ages 0 to 4 who stay over 271 days make up only 6.9 per cent of the total age population but account for 24.2 per cent of the days spent in this category (271+days). Though youth ages 12 to 15 make up only 10.2% of the total age population, they account for 37.5% of the total days in this category (271+ days). This was however, can be expected as the EAPD system primarily served younger children (n= 940) and the younger adolescent (n=992).

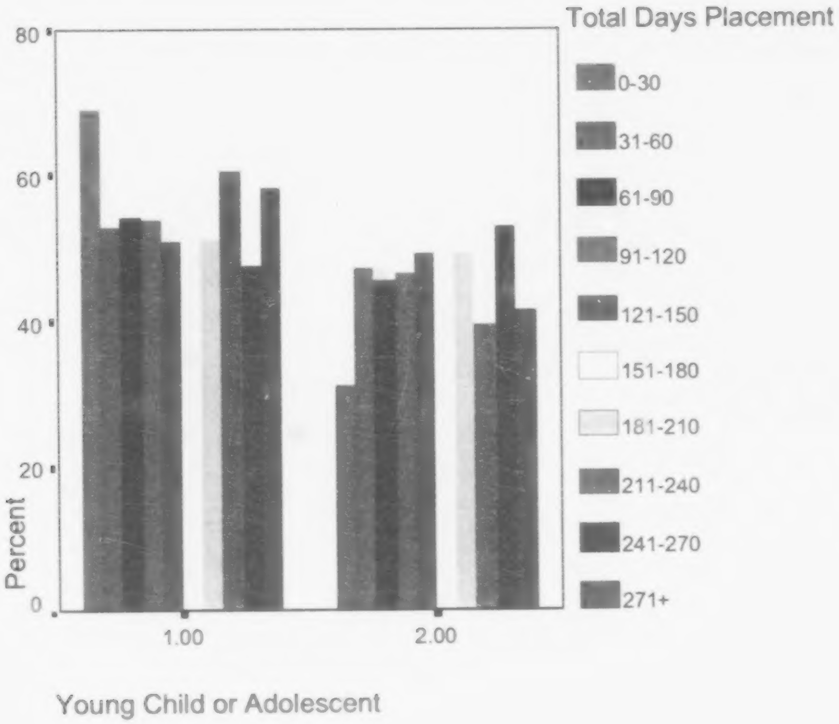
The concern, however, remains that a very young child and the young adolescent can remain in the EAPD system for an extended period of time.

Table 9

Total Days in Placement Care * Age Categories Cross-tabulation

Total Days		Age Categories					
		0-4	5-8	9-11	12-15	16-18	Total
0-30	Count	500	254	172	328	90	1344
	% within Total Days in Placement Care	**37.2%**	18.9%	12.8%	**24.4%**	6.7%	100.0%
	% within Age Categories	**53.2%**	50.5%	40.4%	**33.1%**	40.2%	43.6%
31-60	Count	117	68	53	170	43	451
	% within Total Days in Placement Care	**25.9%**	15.1%	11.8%	**37.7%**	9.5%	100.0%
	% within Age Categories	**12.4%**	13.5%	12.4%	**17.1%**	19.2%	14.6%
61-90	Count	86	40	34	105	29	294
	% within Total Days in Placement Care	**29.3%**	13.6%	11.6%	**35.7%**	9.9%	100.0%
	% within Age Categories	**9.1%**	8.0%	8.0%	**10.6%**	12.9%	9.5%
91-120	Count	42	28	45	82	17	214
	% within Total Days in Placement Care	**19.6%**	13.1%	21.0%	**38.3%**	7.9%	100.0%
	% within Age Categories	**4.5%**	5.6%	10.6%	**8.3%**	7.6%	6.9%
121-150	Count	37	26	15	63	12	153
	% within Total Days in Placement Care	**24.2%**	17.0%	9.8%	**41.2%**	7.8%	100.0%
	% within Age Categories	**3.9%**	5.2%	3.5%	**6.4%**	5.4%	5.0%
151-180	Count	34	17	17	42	8	118
	% within Total Days in Placement Care	**28.8%**	14.4%	14.4%	**35.6%**	6.8%	100.0%
	% within Age Categories	**3.6%**	3.4%	4.0%	**4.2%**	3.6%	3.8%
181-210	Count	25	12	14	41	8	100
	% within Total Days in Placement Care	**25.0%**	12.0%	14.0%	**41.0%**	8.0%	100.0%
	% within Age Categories	**2.7%**	2.4%	3.3%	**4.1%**	3.6%	3.2%
211-240	Count	18	11	11	23	3	66
	% within Total Days in Placement Care	**27.3%**	16.7%	16.7%	**34.8%**	4.5%	100.0%
	% within Age Categories	**1.9%**	2.2%	2.6%	**2.3%**	1.3%	2.1%
241-270	Count	16	6	14	37	3	76
	% within Total Days in Placement Care	**21.1%**	7.9%	18.4%	**48.7%**	3.9%	100.0%
	% within Age Categories	**1.7%**	1.2%	3.3%	**3.7%**	1.3%	2.5%
271+	Count	65	41	51	101	11	269
	% within Total Days in Placement Care	**24.2%**	15.2%	19.0%	**37.5%**	4.1%	100.0%
	% within Age Categories	**6.9%**	8.2%	12.0%	**10.2%**	4.9%	8.7%
Total	Count	940	503	426	992	224	3085
	% within Total Days in Placement Care	30.5%	16.3%	13.8%	32.2%	7.3%	100.0%
	% within Age Categories	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 5



Overall, it appears that over the five years reviewed younger children ages 0 to 11 had a higher frequency of placements in emergency care inclusive of shelters and reported a higher frequency of the total number of days care.

Number of Placements/Re-admission into Care: Children and youth do move in and out of care. The OCA wanted to determine the number of times a child or youth was readmitted to care and ultimately into the shelters. The number of re-admissions into the EAPD system was gathered but this information proved unreliable as the OCA could not determine, from the information provided by WCFS, the discharge placement (where the child went when they left EAPD or agency care). The OCA could not determine if the children and youth were discharged from care to home or were placed in alternative care arrangements and then returned to emergency care. Though the data was and is limited it did point to a possible trend that should be further studied. The data, though limited, did appear to indicate that 84.2 per cent of children and youth had been admitted to the EAPD system once; 14 per cent have had one readmission and 1.4 per cent of the cases have had two or more admissions. The OCA, however, cautions that this data is unreliable and would require further analysis.

Aboriginal Children and Youth

It is well documented that there is an over-representation of Aboriginal children and youth in care of WCFS. The OCA wanted to review the demographic information of aboriginal children and youth as compared to the overall population in order to understand and review their experience and to determine if their experience was different than their non-aboriginal peers. Again this information was collected over the five years reviewed. What the OCA found was that 62 per cent of the children and youth in emergency placements were of aboriginal status; 31 per cent were reported as being non-aboriginal. A breakdown of reported aboriginal status can be seen in Table 10.

Table 10

Aboriginal Status	Frequency	Percent
Inuit	9	.3
Metis	310	10.0
Non-status	279	9.0
Treaty	1315	42.6
Other (Non-Aboriginal)	949	30.8
Unknown	223	7.2
Total	3085	100.0

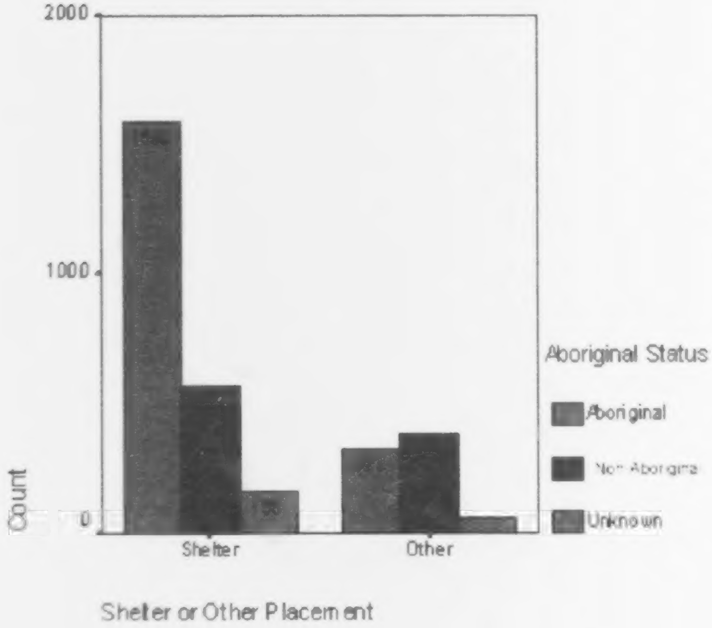
An equal number of male and female aboriginal children and youth were placed in the emergency care placements.

Aboriginal Status and EAPD/Shelter placement: Aboriginal status was examined with placement either in shelter or other emergency placements. As can be seen in Table 11 and Figure 6 83 per cent or **1,590** of identified aboriginal children and youth were placed in the shelters and 60 per cent or **569** of identified non-aboriginal children and youth were placed in the shelters.

Table 11

Placement	Aboriginal Status					
	Aboriginal		Non-aboriginal		Unknown	
	Count	%	Count	%	Count	%
Shelter	1590	83.2%	569	60.0%	158	70.9%
Other	322	16.8%	380	40.0%	65	29.1%

Figure 6



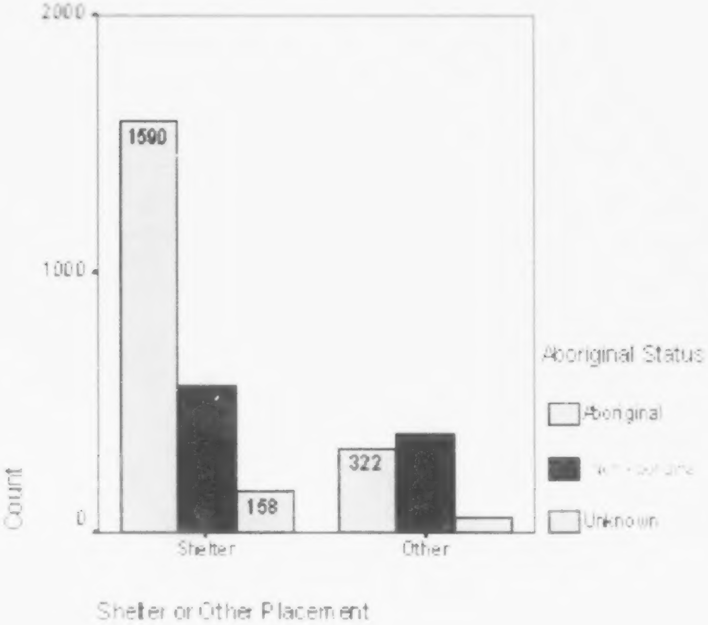
Aboriginal Status and Age and Type of Emergency Placement: Aboriginal status was compared to age of children and youth placed in the emergency care. Consistently among the younger age groups, ages 0 to 11, aboriginal children comprised the majority of the population placed in emergency placements. Alarmingly, as can be seen in Table 12 80 per cent of all children ages 0 to four placed were identified as aboriginal. However aboriginal adolescents, ages 12 to 18, represented the minority of youth placed in emergency care.

Table 12

Aboriginal Status	**Age**									
	0-4		**5-8**		**9-11**		**12-15**		**16-18**	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Aboriginal	748	79.6%	350	69.6%	279	65.5%	446	45.0%	89	39.7%
Non-Aboriginal	122	13.0%	108	21.5%	117	27.5%	480	48.4%	122	54.5%
Unknown	70	7.4%	45	8.9%	30	7.0%	65	6.6%	13	5.8%

Of the identified aboriginal children and youth there is a high percentage of younger children (40 per cent) ages 0 to four in emergency care. In the case of non-aboriginal children, only 13 per cent were between the ages of 0-4 years. This appears to change when looking at youth ages 12 to 18. As can be seen in Table 13 a high percentage, over 60 per cent, of non-aboriginal youth are between the ages of 12-18 years whereas for those identified as aboriginal approximately 30 per cent were between 12-18 years.

Figure 6



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Aboriginal Status	Age									
	0-4		5-8		9-11		12-15		16-18	
	Count	%	Count	%	Count	%	Count	%	Count	%
Aboriginal	748	79.6%	350	69.6%	279	65.5%	446	45.0%	89	39.7%
Non-Aboriginal	122	13.0%	108	21.5%	117	27.5%	480	48.4%	122	54.5%
Unknown	70	7.4%	45	8.9%	30	7.0%	65	6.6%	13	5.8%

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Table 13

Age	Aboriginal Status					
	Aboriginal		Non Aboriginal		Unknown	
	Count	%	Count	%	Count	%
0-4	748	39.1%	122	12.9%	70	31.4%
5-8	350	18.3%	108	11.4%	45	20.2%
9-11	279	14.6%	117	12.3%	30	13.5%
12-15	446	23.3%	480	50.6%	65	29.1%
16-18	89	4.7%	122	12.9%	13	5.8%

Over all it appeared that there was a much higher percentage of young aboriginal children (0 to 11) in the shelters and other emergency placements compared with non aboriginal children. However when examining adolescents in shelters, this difference greatly diminished (51 per cent aboriginal as compared to 45 per cent non-aboriginal). Additionally there appeared to be a higher percentage of non-aboriginal adolescents in other emergency placements as compared with aboriginal adolescents (54 per cent versus 38 per cent).

Table 14

Aboriginal Status	Young Child				Adolescent			
	Shelter		Other		Shelter		Other	
	Count	%	Count	%	Count	%	Count	%
Aboriginal	1299	74.2%	78	65.5%	291	51.3%	244	37.7%
Non-aboriginal	314	17.9%	33	27.7%	255	45.0%	347	53.5%
Unknown	137	7.8%	8	6.7%	21	3.7%	57	8.8%

Aboriginal Status and Legal Status: As can be seen in Table 15 aboriginal children primarily entered into emergency care under apprehension as compared to non aboriginal children. Of significant difference is the VPA status, 33 per cent of non-aboriginal children entered into emergency placements under a VPA as compared to only 11.2 per cent of aboriginal children and youth.

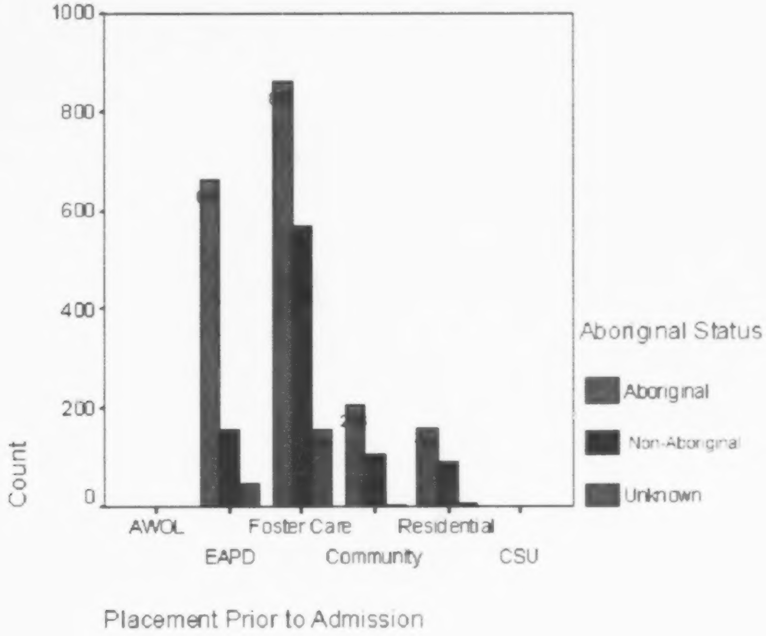
Table 15

Legal Status	Aboriginal Status					
	Aboriginal		Non-aboriginal		Unknown	
	Count	%	Count	%	Count	%
Apprehension	1369	71.6%	521	54.9%	200	89.7%
Permanent Ward	212	11.1%	72	7.6%		
Temporary Ward	105	5.5%	38	4.0%	3	1.3%
V.P.A.	215	11.2%	313	33.0%	19	8.5%
Other	11	.6%	5	.5%	1	.4%

Apprehension from a parent or caregiver is a far more intrusive case decision than is the signing of a voluntary placement agreement. This does not preclude circumstances where a VPA was first signed and the agency then moved to apprehension. However on the surface this statistic is alarming as it may without further analysis suggest a differential case decision-making process. The OCA would encourage further examination of this information.

Aboriginal Status and Prior Placement: A high frequency of aboriginal children and youth entered into emergency placements from foster care (Figure 7).

Figure 7



However, as can be seen in Table 16 a higher percentage of non-aboriginal children (61.5 per cent) entered from foster care compared with aboriginal children (45.5 per cent). Thirty-five per cent of Aboriginal children entered from hotels compared with 17 per cent of non-aboriginal children and youth.

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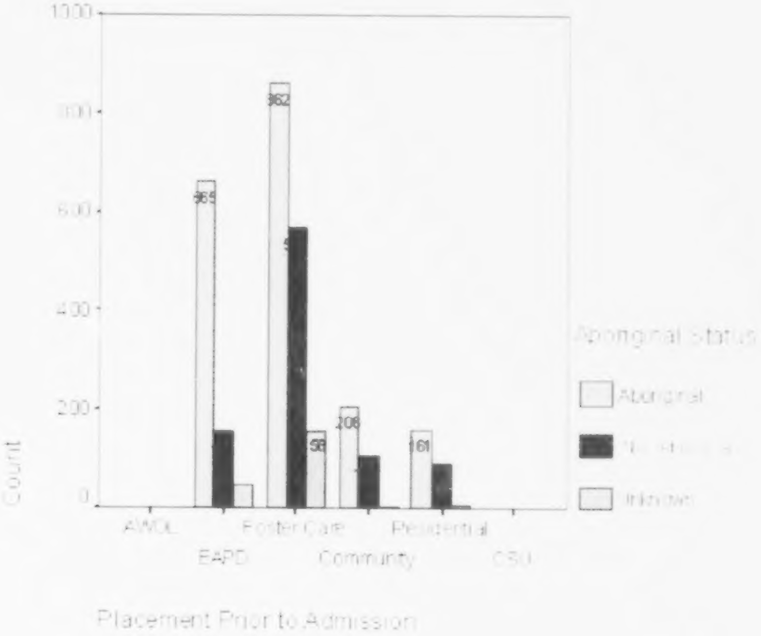

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Table 16

Placement Prior to admission	Aboriginal Status					
	Aboriginal		Non-aboriginal		Unknown	
	Count	%	Count	%	Count	%
AWOL	2	.1%	3	.3%		
EAPD	665	35.1%	154	16.7%	47	21.4%
Foster Care	862	45.5%	568	61.5%	158	71.8%
Community	206	10.9%	106	11.5%	6	2.7%
Residential	161	8.5%	92	10.0%	9	4.1%
CSU			1	.1%		

Aboriginal Status by Days in EAPD Placements: The OCA wanted to determine if aboriginal children were remaining in emergency placements longer than their non-aboriginal peers. While there is a higher number of aboriginal children and youth in these placements the data suggests that aboriginal children and youth are not remaining in emergency care longer than their non-aboriginal peers. Comparatively, as can be seen in Table 17, a higher percentage of aboriginal children (43.4 per cent) are reported to be leaving emergency care within 30 days as compared to non-aboriginal children (34 per cent). However, comparatively, a higher percentage of non-aboriginal children (17.2 per cent) are exiting within 60 days than are aboriginal children (14.4 per cent).

Table 17

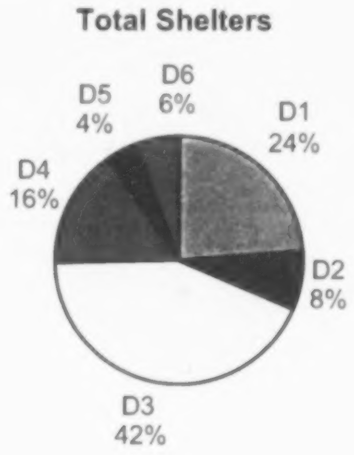
Total Days in Placements	Aboriginal Status					
	Aboriginal		Non Aboriginal		Unknown	
	Count	%	Count	%	Count	%
1-30	829	43.4%	323	34.0%	190	85.6%
31-60	276	14.4%	163	17.2%	12	5.4%
61-90	185	9.7%	104	11.0%	5	2.3%
91-120	134	7.0%	74	7.8%	6	2.7%
121-150	84	4.4%	64	6.7%	5	2.3%
151-180	76	4.0%	41	4.3%	1	.5%
181-210	66	3.5%	32	3.4%	2	.9%
211-240	44	2.3%	22	2.3%		
241-270	47	2.5%	28	3.0%	1	.5%
271+	171	8.9%	98	10.3%		

Again the OCA is concerned that children and youth are remaining in emergency care longer than the recommended 30 or 60 day period. Approximately 40 per cent of aboriginal and non-aboriginal are remaining longer than 60 days.

Where Are the Children and Youth Living

At the time of the OCA review, EAPD consisted of 51 shelters, including a mom and babe home and two professional foster parent homes. Of the 51 shelters reviewed, only one shelter remained unlicensed. The DFSH indicated to the OCA that although this shelter met licensing requirements of zoning, fire and health code, the DFSH refused to license due to its location, its interior condition and layout. The 51 shelters are located throughout the City of Winnipeg. In an effort to ensure safety and confidentiality of children residing in the shelters, the OCA has grouped the locations of shelters according to the Winnipeg Police Service (WPS) districts (see Appendix 3), as can be seen in Figure 8.

Figure 8



Of the 51 shelters, eight homes are owned by the agency, 31 are rented and the final 12 shelters were created through the co-operative partnerships with Manitoba Housing Authority (MHA). As part of the rental agreement, the MHA paid for the renovations to bring its properties to what was considered a rental condition. Six of the 12 MHA shelters, however, were subject to extensive renovations and WCFS paid for any additional expenses necessary in order to bring the facilities up to fire and health code standards as required by licensing. As previously mentioned, only 4 of the 6 renovated facilities were brought to code and licensed prior to children being placed in these shelters.

The shelters have attempted to create a home-like environment within close proximity to schools, parks, daycares, and other community resources. To objectively assess the quality of this home-like environment the OCA created an inspection guide[26] using qualitative measures based upon Child Welfare League of America standards, requirements of provincial child care facility licensing, standards and regulations as well as the program purpose as identified by WCFS. The guide assessed the following areas:

- Physical premises - the physical quality of the building and its surrounding property.
- Proximity to schools, parks and daycares.
- Neighborhood location - where the home is located within the community, ease of accessibility to conveniences and overall community environment.
- Bedrooms and furnishings - living space, personal effects.

- Kitchens - food contents, storage, space, cleanliness, and furnishings.
- Living areas - space, cleanliness, furnishings and safety.
- Hallways, basements and other - lighting, ease of traffic flow, fire code, laundry facilities, air conditioning, alarms, and cleanliness.
- Bathrooms - condition, safety.

The OCA undertook 47 site inspections. The site inspections rated each assessed area on a 3-point scale, with 1 defined as most desirable, 2 as acceptable and 3 as least desirable. During the site visits, the OCA conducted unstructured interviews with the staff regarding shift configurations, household budget, activities and programs provided and frequency of contact with shelter coordinator and children's workers. OCA also reviewed staff and children's logs, and spoke with children and youth present about their placement.

On average, the 47 shelters inspected fell within the level 2 range (acceptable) amongst the areas assessed. However, there were areas that fell into the level 3 category (least desirable). These areas presented concerns that impacted negatively upon the agency's ability to provide a homelike environment. The overall score can be seen in Table 18.

Table 18

TOTAL SHELTERS	
Physical Premises	1.5
Proximity to Schools	2
Neighborhood location	2.5
Bedroom	2
Kitchen	1.5
Living area	1.5
Hallways	2
Bathrooms	2

Key Issues of Shelter Site Inspections

Location of Shelter and Proximity to Services

Physical location was a significant factor weighing upon overall quality of care for children. Many shelters are in neighbourhoods that could present potential safety and risk factors to children. Some are close to major thoroughfares, providing accessibility and ease of public transportation. These shelters are located near junctions of busy streets and high traffic areas that are beneficial for adolescents, and staff who are able to access public transportation. However, this can present a safety factor for young children who may need to cross the street to play in the park.

The majority of shelters are near parks, playgrounds, community or drop-in centres, providing accessible recreational opportunities for children and youth residing in them. Accessibility to such community services was one of the identified criteria the agency used in determining where a shelter should be developed.[27] Unfortunately, some shelters were located near community parks littered with condoms, intravenous needles, and other drug paraphernalia. Although staff indicated that they did not take young children to these parks, the proximity to these environmental safety issues was of concern, particularly for the youth residing in the shelters. Several youth reported they will not use these parks because of those factors.

We found that the proximity of the majority of the shelters to transportation and community resources reflected the agency's initial intent to provide home-like environment, but the individual neighbourhoods of some shelters had a negative impact. Many were in areas where social concerns are evident. Of particular concern are the shelters located within WPS District 1. This area contains 24 per cent of the total shelters in EAPD providing emergency services. Of these shelters, 90 per cent were rated at "3" level due to their close proximity and exposure to observable criminal and anti-social activity (drug trade, adult sex trade) gang activity, abandoned homes, and high incidence of reported crime. It was the collective opinion of the children, youth and the staff that these areas are high risk. Children reported to the OCA that they did not feel safe outside some of these shelters.

In addition to issues of safety, many youth expressed concern that they were placed in homes far away from their families or the communities to which they are connected. Staff within EAPD indicated that children are not placed in shelters connected to the neighbourhood or community in which the child or youth resided prior to EAPD entry.[28] Children are placed according to the vacancy within the specified EAPD license. One 17 year old placed in a shelter in WPS District 6 expressed frustration about having to take the bus for 1 to 2 hours to her place of employment near the north east area of the city. She indicated that each time she visited friends she would have to take into account the lengthy bus ride to ensure she would return to the shelter for her curfew. She further commented that she felt unsafe leaving work at 11p.m. and then waiting 20 minutes to transfer buses downtown at midnight.

Home-Like Environment

The shelters vary in size from a one-bedroom basement apartment, to four bedroom two-storey home. Each home has a kitchen, common dining area, suitable living room space, bedroom(s), and in some cases a staff office. Though the majority of agency staff interviewed stated that the shelters provide a home-like environment, there appears to be a large disparity in the definition of what constitutes home-like.

Some shelters were inviting, contained pictures on the walls, furnishing, wall and window coverings and personal or age-appropriate effects for the children residing there. There were some shelters in all areas of the city that exemplified these home like qualities, but were more evident in WPS districts 4 and 6. Of the 47 shelters visited, three exhibited conditions that were deplorable, and not only defied the concept of a home-like environment but were viewed by the OCA as undesirable for any child. The OCA identified these shelters to the EAPD Project Manager, and appropriate steps were taken to remove the children and close the facilities.

Although generally the majority of the shelters presented a home-like environment, the OCA did note disparities. In some shelters, the common living environments were meticulously structured and organized, while children's bedrooms contained few if any personal touches or effects. As an example, the OCA visited a shelter where a 10 year-old boy had been residing for a period of 15 months. The child's bedroom closet contained only a bureau for his clothes and two books piled on the closet floor. There were no window coverings, no age-appropriate posters or pictures on the wall, and there was no evidence of toys, games, action figures, stuffed animals, or items of interest specific to that child. Further, the only personal item observed in the home was a stuffed craft-style doll made at school by another boy residing in the home.

The need for a staff office also detracts from home-like environments in some shelters. In many shelters, the staff office is locked and located in a bedroom or the basement and so is not obvious to a person entering the home. Other staff offices occupy part of the kitchen, laundry room, or bathroom. In these situations, rules, routines, agency memos and personnel information are left on counters and posted on walls in view of children. In some cases cabinet space is reserved to lock petty cash, log books, or other confidential information. Nonetheless, the accessibility of this information is heightened by its presence in a common area of the home, and creates an environment that appears institutionalized.

Physical maintenance was another important factor. Some landlords are cognizant of the need to perform regular upkeep, paint the exterior of the home and tend to repair items within the home. In other cases, including some of the Manitoba Housing Units, timeliness of repairs was questionable. The OCA visited homes where windows remained broken, screens were missing, and fences and sidewalks were in need of repair. The interior of the homes required repairs to walls that contained holes; water leaks from windows and floors that were pooling in the basement when it rained; broken cupboard and closet doors; broken window treatments; worn flooring, and mold within bathrooms. The OCA alerted the agency coordinators of any repairs requiring immediate attention due to their implications for health risks.

Concerns requiring repair are submitted to the landlord, or the maintenance contractor employed by the agency. However, not all EAPD homes are owned by diligent landlords. Some landlords do not even reside in the province, and others refuse to complete the required repairs, leaving the agency to undertake repairs at their own cost. When the OCA queried agency coordinators about the budget for household repair, we were advised that to their knowledge, there is no definitive budget. It was reported that the only expectation the agency places on shelter maintenance is that "the home is maintained according to the standard of housing in the neighbourhood." This standard can contribute to the disparity that existed amongst shelters.

The problem of household repair has been exacerbated in situations with MHA agreements where MHA is responsible for specific repairs, and the remainder fall to the responsibility of the agency. One staff member within a MHA owned shelter reported that maintenance representatives of MHA once came to the home to see if any repairs were required. Once the staff outlined the areas, the maintenance person said he was going to get tools from his truck, and never returned.

Compounding the issue of home repair by the owner is the ability or willingness of some individual staff to take initiative to complete basic household maintenance. Some shelter staff reported to the OCA that they would simply submit a repair requisition to their coordinator to fix loose cupboards, or even to change a light bulb. In other shelters, staff members have gone out of their way to decorate, make window treatments, and even changed light fixtures. The initiative or lack of initiative by staff to be responsible for the appearance of the home is readily apparent and contributes (positively or negatively) to the home-like environment.

In April 2003 CUPE, the union representing shelter staff released a report, *Investigation into the Shelter and In-Home Support Services of the WCFS Agency* and sent it to the Minister of Family Services and Housing and copied to OCA. This report highlighted concerns of high-risk conditions for staff and children in the shelters (CUPE pp 25-27). The concerns cited by CUPE that shelters were unable to be licensed due to disrepair were not substantiated by our review. In fact, upon review, only one shelter operated without a license, and the decision of the DFSH to withhold the license was an agreed-upon decision between the agency and the department based upon issues of quality, not standards. Further the CUPE report spoke about overcrowding and children being placed without proper licensing variance. The OCA did not observe any home, at the time of inspection, to exceed the capacity specified on the license, or to be operating without a valid variance. It appears that confusion exists regarding licensing variances. Licenses are required by standard to be posted in the facility, while variances are not. Therefore staff, unaware that a variance was obtained, have likely based their opinions on a posted license as opposed to the appropriate variance to the license.

Other concerns raised by CUPE, however, mirrored what the OCA observed during the site inspections. Many of these homes are older homes that require regular maintenance and repair of heating, ventilation and electrical systems. We observed mold, overflowing toilets, windows without screens, and water flowing in the basements of some shelters. The OCA concurs with CUPE statement that the EAPD "has rented homes with no way to monitor slow or negligent landlords" (CUPE 2003:27).

While the OCA noted these concerns, children did not uniformly voice the same concerns about the specific interior physical conditions of the shelters. Many children found the homes to be appropriate and clean. Some children told us that they planted flowers in the spring, and assisted in choosing decorations for the home. While many children felt that they had ample personal space within the shelter, adolescents did express concern with the mix of resident (specific to age and presenting needs), the lack of privacy for personal property and the subsequent inability to have a closet or drawer that they could lock to safeguard personal possessions.

THE VOICE OF CHILDREN AND YOUTH INSIDE THE SHELTER SYSTEM

The OCA interviewed 38 children and youth that had been placed or were placed in the shelters on a randomly selected day. Interviews were conducted using a standard interview survey. The purpose of the interviews was to gain an understanding of their experience in the shelters. Children under 6 were not interviewed.[29]

Demographics of children and youth interviewed:

- Of the children and youth interviewed 31 per cent were children ages six to 10 and 69 per cent were youth ages 11 to 17.
- 64 per cent of respondents were male, and 36 per cent were female.
- 21 per cent of respondents self identified as having treaty status, 28 per cent Metis, 28 per cent other (Caucasian or other ethnic group), 23 per cent could not identify if they were of aboriginal ancestry.
- Most children under the age of 10 were not able to identify their care status, as this concept was not something they understood.
- Of the adolescents interviewed, 26 per cent were in care under a VPA, while 66 per cent were in care through an agency guardianship order (temporary wards 33 per cent and permanent wards 31 per cent).

Here is what children interviewed by the OCA said about the quality of care they receive:

Social Worker Contact

Children and youth were generally able to identify their social worker by name, and were able to clearly articulate the importance of their relationship with their worker. Many youth describe having positive experiences with the social worker, correlating worker contact with their feelings. Other children report having contact with the worker only by phone or during family visits.

> **"My social worker is kind - she gave me food."**
>
> **"I like my social worker, he helps me."**
>
> **"My social worker is hard to get a hold of - I have to phone and leave lots of messages, and then it takes a while before she gets back to me."**
>
> **"It would be nice to see my worker more."**

- 64 per cent of children and youth indicated that their worker has visited them in the shelter.
- 63 per cent of youth indicate that they have contact with their worker by phone at least once a month.

Admission to Shelter

Children and youth are admitted to the shelter by a variety of individuals employed in various capacities within the agency. They describe their admission experience to the shelter with feelings of uncertainty, fear and apathy. Staff members who attempt to make them feel comfortable, by introducing them to the other residents and staff and provide an orientation to the home reportedly ease their feelings.

> **"Staff provided me with an orientation, and told me of their expectations, I was able to know things up front."**
>
> **"This shelter is kind of different than the other one, it has a dangerous neighbourhood because of the gangs."**
>
> **"I was scared but my worker helped me not to be scared."**
>
> **"The admission was kind of quick- I thought it would be longer or something like that."**
>
> **"It's always the same stuff over and over again."**

- 38 per cent of children and youth interviewed were living with a parent or relative before their admission to shelter.
- 1 per cent of children and youth indicated that this was their first admission to shelter.
- 35 per cent of children and youth report currently residing in the shelter for less than a 60-day period.
- 25 per cent of the children reported being in the shelters less than 60 days but 25 per cent reported being in the shelters more than 60 days but less than 12 months. Thirty-three per cent reported being in the shelters more than 12 months. However 17 per cent did not answer or did not know.
- Of youth 33 per cent reported being in the shelters less than 60 days, while 52 per cent reported being in shelters more than 60 days but less than 12 months. Only four per cent of the youth interviewed reported being in the shelter for longer than one year. Eleven per cent did not know or did not answer.
- 65 per cent of children and youth indicated that they had not been told how long they would be residing in the shelter.

School

The continuation of school attendance has been reported to the OCA as being problematic for children and youth in the shelter system. Academic achievement is an important indicator for a child's self-worth, and school attendance is a vital component to a child's overall quality of care. The temporary placement of children inevitably impacts upon their education.

> **"I have been taking the bus to school since I came into care - I made my own arrangements for school."**
>
> **"I would like school better if I was in the grade that I should be in - not three years behind."**
>
> **"I would like to go back to the school I was at before I came to the shelter."**
>
> **"School would be better if I could join the basketball team, and if staff (shelter) could transport me."**
>
> **"I am waiting for my social worker to make the arrangements so I can attend school."**

- 82 per cent of respondents advised they were attending school before placement in shelter.
- Only 66 per cent of those respondents continued to attend school once admitted to shelter.
- Children who did not attend school after being admitted to shelter cite proximity of shelter to their school, and personal circumstances as reason for non-attendance.
- Of the respondents who indicated they were not attending school, only four per cent were enrolled in an alternate day program.
- 20 per cent of youth indicated that they perceived their own lack of academic progress as the reason they "do not like school."
- Youth indicate that placement in age-appropriate grade, more hands-on learning/tutorial aid, and the ability to participate in after school activities would make school better for them.

Programming and Recreation

Life skills, cultural activity and recreational programming can have positive implications for children who are residing in out-of-home care. Programming that is relevant to the age, growth and development of a child may assist with the treatment and care goals for a child in the shelter system. Further, programming assists in promoting emotional and behavioural growth in a structured learning environment, where children and youth can maximize their full potential.

> **"We go to the pool, play Nintendo 64, watch TV and sometimes go to Magic Land if our behaviour is good."**
>
> **"Our programming is going to movies or outside recreation."**
>
> **"The staff took me to the YMCA for exercise."**
>
> **"I am working on independent living skills at the shelter, so I don't have to move again."**
>
> **"A day program would be better than just sitting around."**
>
> **"The shelter should try some after school programs."**
>
> **"A teaching support worker would be helpful."**

- 8 per cent of youth respondents indicate that independent living skills are offered in the shelter.
- Movies and video games are cited by children and youth as the most common form of recreation offered in the shelter.
- 30 per cent of youth identified regularly scheduled physical recreation programs in the shelters.

Basic Care

The Child and Family Services Act, Section 48 outlines the authority of an agency, as guardian, to be responsible for the maintenance and education of a child. T*he United Nations Convention on the Rights of the Child*, article 27 "recognizes the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. It is the responsibility of the guardian to secure these necessary living conditions." The conditions, referred to here as basic care consist of food, clothing, personal hygiene, privacy, health, and routine.

> **"There is not a lot of variety of food in the shelter, often we eat the same food."**
>
> **"It's good, there is food here, there is no money for food at home."**
>
> **"I receive a minimum $4 allowance, and can earn more by doing extra chores."**
>
> **"I can't get clothes until I have been in the shelter for a month. I only have a little bit of clothing from my foster mom."**
>
> **"I have a hard time getting clothing allowance, and money for a winter jacket from my worker."**

- 100 per cent of children interviewed indicated that they have regular scheduled mealtimes, and that they "get enough to eat."
- 89 per cent of youth feel they are provided with enough food.
- 71 per cent of children and youth indicate that they are able to eat when they are hungry.
- 90 per cent of children and youth report receiving an allowance, conditional upon chore completion and behaviour.
- 44 per cent of youth indicate that they do not receive adequate clothing.
- All respondents report celebration of special occasions such as Christmas, Birthdays and Easter.
- 85 per cent of respondents report having medical appointments while at shelter; all indicate that they have received medical attention when it is required.
- All respondents cite having regular routines within the shelter.
- All youth report having basic privacy (being able to shower, bathe, change, use the washrooms privately) within the shelter.
- 37 per cent of youth report having their room or personal property searched by shelter staff.
- 59 per cent of youth indicated that they have had personal items stolen while at the shelter.

Safety

Children entering care have often experienced environments that are unsafe to them. The uncertainty associated with temporary care environments such as shelters can diminish a child's sense of security. The agency must make every effort to ensure children feel physically safe.

> **"I feel safe when I stay inside all day, it's not safe outside, someone tried to beat me up."**
>
> **"I don't feel safe at night, I'm afraid of drive-by's. This sounds stupid but it was real for me."**
>
> **"I feel safe when the other girls in the shelter are not around. They cause a lot of trouble, call me names, and told me my mom drank alcohol when I was in her stomach."**
>
> **"It would be nice if the shelter was in a better neighbourhood."**

"Good staff, good kids. I feel comfortable."

"Some of the kids harass other kids."

- 72 per cent of children and youth report that they feel safe in the shelter.
- 58 per cent of children indicated that they liked the other children in the shelter.
- 78 per cent claim they feel safe outside the shelter when attending school or day programs or accompanying staff on outings. Outside the shelters did not always refer to the neighbourhoods or unaccompanied outings.

A Sense of Security

Shelters are to provide a safe environment for children and youth. A child's sense of security in the shelters is not only affected by the physical environment but also by the mixture of the populations placed in the shelters. Many children are entering shelters from alternative care resources as opposed to their familial homes. Multiple placements can contribute to a child's or youth's sense of insecurity.

- 70 per cent of youth when asked if they had ever "wished" they were some place else other than the shelter responded "yes."
- 41 per cent of youth stated they had run from their current and past shelter placements. Youth who did go AWOL did so primarily because they reported to be "pissed off" at residents or staff at their shelters.
- 33 per cent of children admitted to running away from the shelter. These children advised they left the shelter in search of family or friends.

"Been AWOL a couple of times, but I don't go if I need a meal."

"I ran away because people are bossy here. I wanted to go back home."

"When my grandma died I wished I wasn't there (shelter). I used to be a real suicidal kid. My therapist helped me."

The shelter system serves children and youth ages 0 to 17. Licensing allows for children, ages 0 to 11 to be placed in shelters and youth 12 to 17, to be placed in gender specific shelters. The inappropriate matching of children and youth in either age category can create instability as children and youth with varying needs can react adversely to one another. Without skilled and trained staff such incidents can escalate into aggression.

Generally when children and youth stated they did not like the other children or youth placed with them it was due to age differences and lack of commonalties.

"The shelter needs to have better age ranges. Kids don't like living with babies. The staff attention goes to babies who cry a lot, and then there is not enough time for the older kids. This makes it really boring."

"I can't go out swimming or something else I like unless the little kids are sleeping, or are in daycare."

"When a new kid came in he was calling staff names and I got really scared. I got my slingshot for protection."

> **"The older kid smacked me. Staff said 'just leave it alone." He (older resident) ran away after that and never came back."**
>
> **"I would like to be in a shelter with kids my own age. I could do stuff with other kids like play cards."**

Family Contact

The Child and Family Services Act (1999) declares that children have a right to a continuous family environment in which they can flourish. The Manitoba Standards and Regulations for Residential Care embrace this principle by promoting child-centred and family-focused services in residential care. This includes families actively participating in the child's life where possible and desirable.

> **"I wish I could have longer visits. I get two sleep-overs a month."**
>
> **"I would like to have visitation with my family."**
>
> **"Staff are the only ones that ask if I want to have visits with my family. It is my worker's job to ask, and he never does."**
>
> **"I have the ability to decide if I want to see my family - even if my worker and staff say no."**
>
> **"I can't see my parents, no one said why."**

- Only 69 per cent of children and youth report being able to see their family.
- 7 per cent of children and youth interviewed report visiting with their family at the shelter.
- 77 per cent of children and youth are permitted to have their families contact them by phone at the shelter.
- 52 per cent of youth say no one has ever asked them if they want family contact.
- 48 per cent of youth claim they have unsanctioned visits with family that workers do not know about.

Friends/Peer Contact

The development of social relationships with peers assists a child with sense of identity. This sense of identity is partially formulated through a child's comparison of self to others. The ability of a child to form social networks enables development of physical and social skills, moral and ethical values and overall knowledge that will equip the individual to function in society (Kufeldt, et. al, 2000).

> **"When I go out with my friends, I need to have them drop me off one block away from the shelter, and then I walk back, because I am not allowed to let them know where I live."**
>
> **"Friends can not know the address of the shelter. It's a safety issue, in case of break-in."**
>
> **"I was not allowed to see my sister, she is not allowed at the shelter. My social worker said yes, but the staff say they need to hear that too. But, they let other kids' foster mom's visit."**

> **"It is hard for me to see my friends because I am placed so far away. I am not allowed to stay at their place overnight."**

- Only 33 per cent of youth are permitted to have friends visit at the shelter; and rules stipulate visits on the main floor or outside.
- 92 per cent of children interviewed indicate that they are not allowed to have friends at the shelter; they can see them only at school.
- 67 per cent of youth respondents indicate that, if permitted, they would invite their friends to the shelter, while 26 per cent indicated they would not want their friends to see where they live.
- 100 per cent of youth report being able to contact friends by phone; children are not able to identify ability for phone contact.

Interactions with Staff

Staff are the primary caregivers for children within the shelter system. Dependent upon length of stay and the age and developmental level of the child, staff can have considerable influence over a child's sense of identity. Children should be "encouraged, loved and supported by sensitive and responsive caregivers. Optimal identity development occurs when a child has good attachment experiences, leading to appropriate cognitive development and value choices" (Kufeldt et. al 2000:36).

> **"All staff working within the shelter should make the shelter feel like a home. It means that the staff should get along with each other, not just the kids."**
>
> **"The staff are very nice, they joke around with you, and they point you in the right direction."**
>
> **"I don't like it when staff kick me out of the house everyday between 10 (a.m.) and 4 (p.m.) so they can do things. I have nowhere to go, I try to get my friends up in the morning so that I have something to do."**
>
> **"Some staff inflict their own personal views, morals, religion and culture, and make judgments on youth in care. Some staff just shouldn't be working with kids."**
>
> **"Staff person (name) and I can talk. I trust her, and we do things together. We talk about future plans. I find the staff easy to talk to."**
>
> **"They (staff) say a lot of swears it happens all the time."**
>
> **"I am told to sit the fuck down."**

- 33 per cent of youth interviewed identify having a primary worker who assists them with issues and interacts with them regularly.
- 48 per cent of youth find it helpful to confide in a counselor that they see outside of the shelter setting.
- 50 per cent of children interviewed reported that staff "yell too much."
- 22 per cent of the youth reported that staff swore at them.

Behaviour Management/Intrusive Measures

Rules are the mechanism by which care facilities promote stability. The DFSH Child Care Facilities licensing and standards manual states that behaviour intervention should be most appropriate to elicit alternative behaviours to acting out, and discipline should be least restrictive. Physical restraint should be used as the last resort.

> **"When we get into trouble, we get disciplined. Last time we got 500 lines for going AWOL."**
> **"I get sent to my room - sometimes I ask why cause I don't know, then I get told to spend more time there, which is cheap."**
>
> **"I lose privileges and the phone and TV if I break the rules."**
>
> **"If we don't clean our rooms, we lose allowances, if we AWOL, we are grounded for a week."**
>
> **"If I go AWOL for longer than 2 days, I lose my bed space - and have to move."**
>
> **"Staff put me down and are condescending when I have my crushes."**
>
> **"Staff make comments about us."**
>
> **"They (staff) roughhouse with me; it hurts."**
>
> **"I get restrained if I fight other kids."**
>
> **"I was on my stomach, they (staff) pressed their knees on the back of my knees with all their weight. They (staff) pulled my hair, so I bite them so they could feel my pain."** (It is important to note that this child was describing a past experience and not a current situation with current staff.)

- 59 per cent of children and youth report use of time out in their room as punishment for behaviour, or violation of shelter rules.
- 22 per cent of youth report being physically restrained by staff, but only seven per cent acknowledge any attempt of staff use verbal de-escalation before restraint.
- 22 per cent report involvement of Winnipeg Police Service in behaviour management, to address issues of children and youth whom or were beyond staff control.
- 18 per cent of youth interviewed claim they are on prescribed medications to assist them in controlling their own behaviour.
- 30 per cent of children and youth report that staff attempt to speak with them after they have been disciplined.
- 33 per cent of youth report feeling humiliated and put down by staff.

Violence

Issues of self-identity for a child or youth are compounded by the social influences, beyond families, that shape their behaviour. Within group placement settings, the peer-to-peer subculture tends to influence non-compliant or anti-social behaviours. Staff confronted with incidents of aggressive and destructive behaviour, and must react (Rosen, 1999:665). Issues of training in addressing peer-to-peer conflict and individual aggression are paramount to the treatment process.

> **"I am placed with another kid who is 12. It is really hard to live with younger kids."**
>
> **"He (other resident) is always in my face instigating me, I am gonna just beat him up."**
>
> **"I get aggressive when people taunt me, pick on me, or when they tell me no."**
>
> **"The constant bugging needs to stop. I should not be getting angry every day."**

- 15 per cent of youth indicate that they have witnessed violence towards staff perpetrated by other residents, while 19 per cent admit to assaulting staff.
- 19 per cent of youth worry about being hurt by other youth in the shelter.
- Only 52 per cent of youth state they would report to staff, violence directed towards them by another resident.

Grievance

Article 12 of the *United Nations Convention on the Rights of the Child*, states a child who is capable of forming his/her own views has the right to express those views freely, and has the right to be heard in all matters affecting the child. It is vital that a child participates not only in overall case planning with the social worker, but also in treatment planning within their care residence. "A child's right to due process within a residential facility can by assured by the formation of a child grievance protocol" (Triantafillou, 1999:14). The DFSH Child Care Facilities licensing manual indicates that the facility should develop and maintain a client's rights policy ... and must ensure that all residents are aware of the grievance procedure (p.55).

> **"If I had a problem with one staff, I would talk to another staff."**
>
> **"There is a poster of the OCA in the shelter, but no one told me about it."**
>
> **"I know that I have the right to have a say, to feel safe, be properly cared for, and the right to complain or disagree."**
>
> **"If I had a complaint I would speak with my social worker, or the shelter coordinator."**

- 75 per cent of children and 66 per cent of youth could identify someone they could talk to if they had a problem at the shelter.
- 38 per cent of children and youth report that they were told about the Office of the Children's Advocate.
- Only 11 per cent of youth were able to acknowledge that they were aware of VOICES – Manitoba Youth in Care.

- 52 per cent of youth were able to identify that they had rights, but were not able to articulate these rights, nor were they able to identify how they could be realized, beyond speaking with staff.
- Children were unable to identify a formal process within the shelter to lodge a complaint.

Discharge Planning

The DFSH Child Care Facilities Licensing and Standards manual outlines the process to be followed when a child is discharged from facility. As the shelter system is a short-term emergency care system, it is required by standard that tentative discharge plans should be identified at the time of placement, and should be reflective in ongoing planning for the child/ youth. Every effort should be made for the child to say good-bye in a healthy way to staff and other residents (p. 34-35).

> **"I have no idea where I am going to live. My mom may be moving, but I would like to live with her, my worker says he is looking for a more permanent placement which means foster care."**
>
> **"Maybe I'll go to a foster home, and maybe not."**
>
> **"I will go with either my mom or my dad."**
>
> **"I wish I could live somewhere where everything is free and there is no rent or payments. When I lived with my mom, I had to pay for my own clothes and glasses."**
>
> **"I am going to a foster home – temporary - until I return home with dad."**
>
> **"I am here until my social worker finds a proper placement, or independent living."**

- 64 per cent of children and youth interviewed reported they want to return to live with parents.
- 83 per cent of children report that they have not been asked by anyone the question of where they would like to live.
- 44 per cent of children and youth have no idea where they will reside after they leave the shelter.
- Children and youth report that some children are privy to a good bye celebration when they are leaving the shelter.

Additional Comments from Children and Youth

> **"It would be nice to have Play Station 2, more space, a big yard to play in and a safer neighborhood."**
>
> **"Better food. If I ever go back to a shelter, I would like a say on what kind of food is there, and more recreation activities."**
>
> **"The shelter would be better if there were kids to play with, and if friends could come over."**
>
> **"Girl decorations in the house and room - like pink flowers."**
>
> **"What would help other kids coming to shelter: Kids really need to know about the rules in the shelter, and how stuff happens."**

"I am very comfortable at the shelter. There is no pressure for me to be someone that I am not, and staff don't pretend to be my family."

"The staff should have more time out of the shelter. They should be working with someone, someone who makes this place feel like home. So that when you come home you have someone to talk to, so you don't have to go to your room."

"I would like the shelter to be fixed up a bit, the bathroom is a mess. The stove is so old it makes funky smells. This is a nice place, but they need to fix it up. Paint the walls because the paint is falling off. They need to do house maintenance, fix the leaky toilets, update some of the cabinets, and decorate the yard."

"I like to help people and teach people things like schoolwork. Adults need help from kids too."

REFLECTIONS OF STAFF

Staff in the shelter system have a responsibility to provide basic care, household maintenance and support. Staff are also responsible for the basic assessment of the behavioural, social and life-skill issues for children and youth, despite having received little to no training in assessments. Shelter staff are not only the primary caregivers to children and youth in the shelter but also they are, and should be, the liaison for the child within the CFS system.

The OCA interviewed 25 shelter staff.[16] Shelter staff both permanent, casual and contract staff were provided a letter written by the OCA outlining the purpose of the review and indicating that the OCA would contact them. Employing agencies were requested to send the letter to their staff at their home address, as staff addresses could not be provided to the OCA for privacy reasons. The OCA then, from an agency provided staff list of assigned staff in each shelter, randomly selected staff and contacted staff at their place of work to determine if they would be willing to participate in the interview. In addition any staff person who wanted to be interviewed and were not randomly selected were provided an interview within the time period allotted. Once the set number of interviews (25) were met interviews were closed.

What follows are reflections of shelter staff on the EAPD system as it pertains to the care of children.

Admission to Shelter

Staff see children and youth entering the shelter not only from home or relative care, but also from a variety of resources within Manitoba's Substitute Child Care Resources, adding children and youth that have been released from correctional or mental health facilities. The behaviours of these children and their level-of-care needs vastly differ. Given that only age and gender are specified in EAPD admissions policies, staff consistently report that often children and youth are not appropriately matched for shelter admission. It was reported that older children are mixed with infants; children and youth with mental health issues or suicidal thoughts have been paired with children and youth that do not possess the same issues; youth with gang affiliations are mixed with non-streetwise youth. Further, children and youth who exhibit profound developmental delay or who are multiply handicapped, are isolated from other children and remain in shelter for lengthy periods of time awaiting specialized placements.

These concerns are echoed by shelter co-ordinators. Co-ordinators report that in the early years of EAPD operation, careful attention was paid to matching children and youth to the shelter and to the suitability of staff. Now the focus is on using the bed-space, as opposed to suitability.

Inappropriate matching is compounded by the lack of information received about a child upon admission. Often shelter staff and co-ordinators receive only minimal identifying information, such as names, age and gender when a child is admitted. It should, however, be noted that during emergency placements social work staff might not have all the information available to provided as they too maybe largely unaware of all the child's information. Shelter staff, however added that important information regarding the child's reason for admission, family information, medical issues, and case plan is received at a much later date. Staff reported that some of the missing information is vital to ensure a child receives appropriate care from the outset.

Rights and Grievance Procedures

Staff reported that children and youth (where age appropriate) receive a general orientation to the shelter, and are advised of the shelter rules and routines. However, staff feel that rules and routines within the shelters are not applied consistently and fairly to all children and youth. Further, staff indicate that children and youth are not fully aware of their rights, grievance procedures, or their ability to lodge a complaint. Some staff have indicated that although children and youth may be aware of the Office of the Children's Advocate (OCA), within certain shelters children are not encouraged to contact the OCA, nor are staff permitted to contact the OCA on a child's behalf. This statement had been verified by co-ordinators who feel that it is more appropriate for youth to make a complaint inside the EAPD system by using co-ordinators, social workers, or supervisors. On the other hand, other co-ordinators encourage the involvement of the OCA in advocating for children and youth, specifically as it relates to external systems such as education.

Contact with Case Worker

Staff also echo the comments of children and youth around the difficulty with connecting with a child's caseworker. Social workers can often impact upon a child's quality of care within the shelters as they possess the ability to provide consent, as a child's legal guardian, for participation in events. School field trips, medical intervention or appointments, family contact and visitation, and shelter outings beyond the Perimeter require consent of the worker. Shelter staff report that workers are generally accessible, but sometimes difficult to reach because of their workload demands. Shelter staff indicate that they usually have monthly contact with a worker by phone, bi-monthly in person. Staff said their ability to provide care would benefit from increased feedback, communication, and contact with the social workers.

Co-ordinators report having greater accessibility to a social worker, but that contact varies in frequency, and purpose. Co-ordinators view their role as being the liaison between the shelter staff and a child/youth's social worker, arranging case conferences, and sharing information about the child/youth with the social worker. While co-ordinators act as intermediaries in the provision of planning for children within their shelters, the inability of shelter workers to have direct contact with social workers for issues or events requiring guardian permission have negatively impacted upon children and youth's daily activities.

School and Programming

School attendance for children in the shelters is inconsistent at best. Shelter staff report that almost one third of the children do not attend school after admission. Issues such as transportation, enrolment in new school, proximity of shelter to initial school, and lack of communication with school personnel have been identified as barriers to school attendance. Staff report attempting to address some of these barriers by facilitating transportation, and scheduling time for homework within the shelter.

Co-ordinators and shelter staff attempt to enroll children in school once they have been in a shelter for longer than three days. However, co-ordinators report that the geographical boundaries of the school system do not facilitate continued school attendance. A child may be required to transfer schools if the shelter is located outside the school boundary. In order to maintain a child's school attendance, extra effort in arranging transportation is required, but not always readily available.

For children and youth who do not attend school, very little is available to them by means of alternative programming. Some alternative programming is found within the community; employment preparation programs and day-care are suitable examples. Within the shelter, staff report providing alternative programming by way of life skills training and health education, but little formalized and structured programming is available to children and youth. Co-ordinators have indicated that programming depends upon the complement of children in each shelter, and whether shelters are double staffed. They add that more could be offered to children in the shelters if programming was formalized. The primary program provided by staff within the shelters is a recreation program, as required by licensing standard.

Some shelters provide a structured time each day for recreation, while others offer recreation less than twice per week. Inconsistencies in the definition of recreational activity exist amongst shelters. Some shelters define it as any type of physical activity, while others classify it as a leisurely outing to the movies, or watching television.

Family and Peer Contact /Visitation

Staff report that children and youth all have contact with their families outside of the shelter. Generally, family visitation is prohibited inside the shelters, but telephone contact is permitted. On the rare occasion that family is allowed to the shelter, prior authorization must be obtained from the child/ youth's caseworker. This family member is usually a sibling. Co-ordinators report that they generally do not encourage family contact, aside from siblings, within the shelter, as the shelter is to be a safe place for all residents and staff. Invitation of family members to the shelter could potentially compromise the safety of all in the home. However, each shelter differs in applying this policy.

The inconsistency in the application of visitation policies within the shelters extends to a child's or youth's peers as well. Some shelters prohibit peers from visiting children and youth at the shelter, while others place parameters on the visitation. Such parameters include: friends can only be outside, friends can only visit in the main living areas, and a friend can stay for dinner once. If shelters do not permit peer contact within the shelter, there is no expectation that the shelter will find other opportunities for children to have peer contact. One staff advised that they would take the children to the park where their own children are playing, just so that the children in the shelter can have opportunity for peer interaction.

Further policies govern residents' use of the phone for social reasons. Children and youth are not permitted use of the phone during business hours, they are often time limited from 10 –15 minutes, and use of the phone is contingent upon behaviour. Staff are also reporting that they are expected to monitor telephone conversations of children/youth.

The issue of telephone use by shelter residents to contact family and friends has been a contentious issue amongst shelter staff since the agency decided to remove the teen phone lines for budgetary reasons. Many staff feel that peer contact is necessary for children and youth to develop appropriate social skills, and as a result, these staff report they do not enforce the rules associated with peer contact.

Basic Care

Overall, shelter staff make every effort to ensure children receive the basic care they require. Children and youth are encouraged to participate in meal planning where age appropriate, and staff routinely make provisions for children/youth who require special diets. Staff report to using the Canada's Food Guide in meal planning, but also report to the OCA that in cases of larger shelters, budgets do not always enable food choices to be reflective of the Guide. Staff stated that in these cases food choices were non-perishable high carbohydrate food groups as opposed to protein enriched food.

Personal hygiene items and clothing are provided to each shelter resident, and the shelter co-ordinator monitors the maintenance and provision of these items. Shelter staff encourage and monitor personal hygiene practices of residents, and facilitate regular and as required medical appointments for them. They also assist children and youth with activities of daily living including maintenance of the home through chores. Each shelter assigns chores within the home to children and youth, where age appropriate. Children and youth are encouraged to take responsibility for their living environment, and can earn an increased allowance for demonstrating a commitment to the everyday maintenance of the home. If a resident is unwilling to complete chores, they are not forced to comply. However, they do not receive any additional financial incentive. The base allowance of $4 per week, as per licensing regulation, is provided to those who do not complete chores. Those who complete household chores have an opportunity to earn $10 or more depending upon the shelter.

Shelter staff also attempt to institute a regular routine within the shelter, consisting of regular mealtimes, curfews, bedtimes, and structured free/play time. They also try to take the opportunity within playtime and other unstructured times of the day to interact socially with children and youth. Staff report going on outings, attending movies, and playing games with youth and children.

Safety

Staff report that safety can be a major factor impacting upon the quality of care of children and youth within the shelter system. They agree with children and youth that location of the shelter can be the largest safety concern for children and staff. Other safety issues result from the inappropriate matching of residents within the shelter resulting in individuals placing one another at risk for harm. Verbal and physical threats and intimidation are identified as the usual form of peer on peer violence within the shelter. As potential negative factors they cite age differences, gang affiliations, aggressive and negative behaviours and placement of high-needs children with lower-needs children, and a lack of trained staff and staff inconsistencies.

Despite the fact that 72 per cent of staff say a resident in the shelter has assaulted them, staff report generally feeling safe. However, risk levels increase dependent upon the complement of children in the home, the amount of information provided to staff about the children, and inappropriate staff responses to resident aggression. Sixty-four per cent of staff report that they have seen inappropriate staff response escalate an aggressive youth's verbal or physical aggression towards a child. Staff also believe the level of risk to themselves in the shelter can be minimized through the provision of more relevant training opportunities.

Behaviour Management

Shelter staff reported that they manage children and youth behaviour primarily through the restriction of privileges, verbal redirection, and the use of time outs. Staff are unable to consistently describe the EAPD policy with respect to behaviour management beyond utilization of non-violent crisis intervention, or restraint as a last resort to manage a child or youth's aggressive behaviour. Yet, 20 per cent of respondents report using physical restraint on children between the ages of six and 12. And, although saying it happens infrequently, 68 per cent of staff advise that they have used physical restraint at some point in their career within WCFS.

Discharge Planning

This area has been identified as the most uncoordinated component of a child's placement within the EAPD shelter system. Staff report that there is no process, beyond completion of paper work, for a child to be discharged from shelter care. Often, the shelter receives notification the day before a child's exit from the EAPD system, but is unaware where that child will be going. Consequently, staff have little ability to assist the child emotionally with their transition. Shelter staff report that they attempt to provide each child a good-bye celebration prior to their exit from the EAPD shelter system. Unfortunately, there is often little notification that a child or youth will be discharged from the shelter. Often, children have only hours to pack their belongings, say goodbye, and move to the next resource. One staff commented on how sad it was to see these children transition to resources unknown. These children are referred to within the shelter system as "the garbage bag kids," because they arrive with their belongings in a green garbage bag and leave the shelters, their belongings again packed in a green garbage bag.

THE CRISIS IN FOSTER CARE

"Foster Care has been allowed to fall into serious disrepair" (PRA, 1997, p.106)

A foster home is defined under Manitoba's Child and Family Services Act as "a home other than the home of a parent or guardian of a child, in which the child is placed by an agency for care and supervision, but not for adoption." Each CFS agency and or regional office of the DFSH "is responsible for the development, utilization, maintenance and co-ordination of the foster care program within its jurisdictional boundaries".[31] Though agencies can recruit, train, license and support foster homes it is the province that sets the rate of compensation.

In 1997 the Prairie Research (PR) report highlighted to WCFS that "the ratio of admission of children in care to licensed foster homes has fallen below one, indicating that the turnover of children in care has slowed.... More children are coming into care and are staying longer." The report concluded that "the agency has responded to the shortage in foster care and the high cost of treatment foster care by creating a number of four-bed units that serve as emergency housing" (p. 90). Agency staff, from the shelter worker to senior managers told the OCA that the EAPD program emerged and grew with such vigour because of the lack of available alternatives, specifically foster homes.

WCFS, as of July 22, 2003, reported having 753 licensed foster homes[32] with 1,654 beds. In 1995 WCFS reported having 835 licensed foster homes (PR, 1997: p. 70); total bed space is unknown. It therefore appears that WCFS has fewer foster homes where they have control over admission in 2003 than they did in 1995.

In 1995 WCFS had 2,630 children[33] in care and in 2003 WCFS had 2,525 children[34] in care, a decrease of two per cent. If one reviews the number of days in care between 1995 and 2003 one can see that the number of days children spent in general foster homes has decreased by 20 per cent. However, the number of days in care children spent in higher levels of foster care or foster homes that specialize in providing care to high-needs children increased by 14 per cent. Overall the total number of days spent in foster care Level 1 to 5 has increased by approximately two per cent.

Table 19
Days in Care: Foster (Regular/Special)

Year	# of CIC	Regular Rate Foster Care	Level II – V Foster Care	Total Days In FC
1995	2630	336,764	416,684	753,448
2003	2525	223,629	556,883	780,512
	(- 105)	(-113,135)	+140,199	+27,064

Finding alternative care, particularly for high-needs children, appears to be a very real pressure for WCFS staff. Staff responsible for securing placements reported that in 2002 the internal placement desk fielded 1,807 requests for placements for children not already in a stable care resource.[35] WCFS does not appear to have the capacity to place these children in agency-controlled foster care as the number of children requiring placement outnumbers the number of suitable foster care placements available. WCFS staff interviewed for this review (shelter to management staff) all have stated that many of the children requiring such care then enter into the shelter system and many stay longer as alternative foster care or residential care resources capable of meeting their needs are simply not there.

In 2000, the provincial government undertook to restructure the child and family services system in Manitoba. The government in partnership with the Manitoba Metis Federation, Assembly of Manitoba Chiefs and Manitoba Keewatinowi Okimakanak developed what is known as the Aboriginal Justice Inquiry-Child Welfare Initiative (AJI-CWI). This process will see the return to First Nations and Metis people the right to develop and control the delivery of their own child welfare services.[36] In the AJI-CWI Detailed Implementation Plan (DIP) released in 2002, the provincial foster care system is reported to being reviewed. The DIP outlines a sub project that will see the restructuring of the provincial foster care system.[37] The design and implementation of the new foster care system is to be concluded by April 2004. The DIP outlines the timelines and work tasks required to transfer the existing foster care system to the four authorities and the development of the new foster care system including a foster home appeal procedure. How this plan will impact on the recruitment and retention of additional foster care resources is yet unknown.

What has been clearly stated to the OCA during this review is that there currently is a chronic shortage of foster homes in the CFS system. As stated by the CWLC (2003) there is a general shortage and a specific shortage of family-based resources across Canada. In Manitoba there currently are high rates of aboriginal children in care and an insufficient number of culturally appropriate homes. The Manitoba Foster Family Network (MFFN) reported to the OCA, though their information is anecdotal, they believe the shortage of foster homes is province wide. They added:

> **"It is a continuous cycle of never having enough foster homes."**

Why is there a crisis?

Many in WCFS believe that the needs of the children and youth entering care are now higher than a generation ago. As stated by one manager of WCFS,

> **"The needs of children coming into care are much higher now than people are prepared to accept. People used to foster babies, primarily to 'feel good,' now we have crack and FAS/FAE babies and their needs are too high."**

The MFFN also stated that the increasing needs of children and youth coming into care has also resulted in fewer people being willing to foster.

There are generally believed to also be environmental and systemic reasons that have contributed to the decline in available foster care beds across Canada and include:[38]

- The increase of two-wage earner families. The impact of this economic reality for families can affect an agency's ability to recruit and support homes. Agencies are limited in their ability to provide "income replacement" for such homes. As well, some potential foster caregivers may be unwilling to leave a work environment to foster. WCFS staff and managers informed the OCA that children with high needs often require a constant caregiver. A child with high needs may be suitable for a community foster home placement but the agency may be limited in their ability to recruit and support families where both caregivers work.

- Increased number of single-parent homes.
- The lack of foster parent training and ongoing support. The MFFN reported that foster families may not have consistent access to training and that the provincial foster parent manual put out by the DFSH is not available to all foster parents.
- The high number of aboriginal children and youth in care and the lack of sufficient number of culturally-appropriate homes.
- The "perceived bureaucratic process" of becoming a licensed foster home in some Canadian jurisdictions.
- The lack of culturally sensitive and realistic recruitment and licensing process for aboriginal and other minority communities.
- The perceived "poor public image of fostering."
- The current shortages of foster homes can often result in the inappropriate matching of child to foster home which can contribute to foster care breakdown or over use of a foster home which can contribute to foster parent burn out. Foster parents then leave the system closing their home as a potential placement option for children and youth.[39]

Four additional reasons were provided to the OCA during this review that demonstrates particular provincial issues:

- Managers in WCFS have said they are unable, given what they described as an often uncertain and constantly changing environment, to focus their efforts on the recruitment and retention of foster homes. One senior manager said staff time diverted to the AJI-CWI process and the government "take over" of the agency has made it impossible for the agency to consistently focus on other areas such as the recruitment and retention of foster parents.[40]
- Foster parents have complained about the restrictive policies surrounding respite use in foster care. The MFFN says a foster parent's request for additional respite is often looked at as an inability to cope. Respite typically is to be used to hire a respite worker to take the child out of the home or allow the foster family to leave the home while the foster child remains cared for by a respite worker. Respite is seen as a break from the child. The MFFN stated that this thinking is outdated and that respite means many different things to different families to address multiple situations. Foster parents should be able to access respite and incorporate respite services, as the family deems appropriate not the agencies.

  WCFS has recognized this issue and said, in the 2002 Support to Foster Parent Task Team: Final Report, that appropriate access to respite can reduce foster home breakdown. The Task Team recommended a series of actions including additional financial support, the recruitment of respite workers for foster homes, the recruitment of respite foster homes and the development of a telephone support line for foster homes. It is unknown to the OCA if any of these recommendations have been implemented.
- As reported to the OCA by MFFN there still exits a perception that foster parents are not an integral part of the treatment team for a child. They feel they are team members who possess vital information about the child and who are required to implement many of the intervention or treatment recommendations for a child. According to the MFFN there still exist situations where foster parents are not provided with needed information about children in their care. In such situations foster parents are often operating blindly or unknowingly entering into conflicts with the agency or birth family. Many agencies are requiring foster families to work with biological families. Many are achieving success, but

such success is not compensated or considered in the foster care rates. As stated by the MFFN;

> **"The view of foster parents should be that they (foster parent) are part of the team and are the social worker's right hand. They should not be viewed as part of the caseload."**

- WCFS current practice and policy with respect to special rates, according to the MFFN, has impacted on children and youth in care and has contributed to foster placement breakdown. The MFFN says there is a freeze on special rates in WCFS. The current practice allows for foster parents in conjunction with agency staff to determine the special rate when a child enters or soon after s/he enters the foster home. That rate is set and frozen. The foster parent cannot renegotiate. As well, there is a general feeling that if a foster parent asks for an increase in the special rate, this is negatively perceived by WCFS. However, if a breakdown occurs and a child has to move to a new foster home that new home can negotiate with the agency a higher special needs rate.

A Case for Compensation

"There is value to this work."[41]

Foster care rates are established by the province. In June 1994 government policy was introduced that provided a reduced rate for the basic maintenance to be paid for family members who provide for care for children. The belief was that family members had a responsibility to care for their children. The basic family rate was substantially less than the regular rate. In 1994 the family rate was $10.97 per day in the south and $11.52 in the north. At this time the regular rate was $16.23 to $20.15 (depending on the age of the child) and $17.04 to $21.15 in the north.

The OCA is unaware of any studies conducted to evaluate the long-term impact of these policies; however, anecdotally agencies did report a negative impact. The introduction the family rate is believed to have had a dramatic impact on the foster care system and the number of families prepared to care for their relative's children. The family rate had the greatest impact in aboriginal communities, whose agencies for historical and cultural reasons place children and youth in family or kinship homes.

This policy was rescinded in October 2001 and now regular foster care rates apply to both kinship and non-kinship homes. The rate is intended to cover the basic maintenance for a child. These rates have been increased and rates are higher in the north than in the south to recognize the higher costs of living, particularly in those communities that have no road access.

The rates have not increased significantly, as can be seen in table 20.[42] (For a full breakdown of foster cares rates please see Appendix 4).

Table 20

Foster Care Rates[1] (Total Rate)
1997-1998 compared 2003-2004

	1997-1998				**2003-2004**					
	South of 53		North of 53		South of 53		North of 53		North 53 East of Lake Wpg. No Road Access[2]	
Age of Child	0-10	11-17	0-10	11-17	0-10	11-17	0-10	11-17	0-10	11-17
Daily Rate	17.56	21.48	18.43	22.54	18.36	22.46	19.56	32.91	21.49	26.37
Monthly Total (30.5 days)	535.58	655.14	562.11	687.47	559.98	685.03	596.58	729.25	655.44	804.28

The OCA does, however, acknowledge that the province has attempted to address the funding inequities of foster parents living in northern Manitoba, particularly those foster homes in isolated communities with no road access.

Despite the difficulties in the compensation for foster parents, fostering is still considered to be a cost-effective form of care. As reported by Kluger (2001) in the CCWL report *Children in Care in Canada*, "treatment foster care is significantly less costly than group care, with estimates showing foster care to be 20 to 30 per cent less costly than residential group care."

The Unintended Impact of the Shelter System

The shelter system was created partially because of the perceived lack of foster care, particularly for younger children. However, the placement of children and youth in the shelters may have unintentionally contributed to the resistance of potential foster parents to accept children and youth from the shelters. As stated by an MFFN member:

> **"Shelters are fast-food service. I will not take children coming from group care. In group care, staff treat the children differently than we do in foster care. Shelter staff entertains them, feeds them, and clothes them. Staff tells the kids you do not have to make your bed and you will still get allowance. I won't take any child who has been in group care for over two weeks. These kids tell you how to do your job because that's what you get paid for."**

On the surface this attitude may be shocking to those in our system. However some studies do suggest a link between admission at an early age and prolonged residential care placements and later breakdown in foster placements (Berrick et al 1998:86). A child's stay in shelter may lengthen as either potential foster parents are unable or unwilling to take children from shelter care, or prolonged stay in a shelter may impact on the child's ability to transition to foster care.

WCFS staff reported to the OCA that they believe that a large number of children and youth that have been in high-cost treatment foster homes or residential care are being returned to the shelter system. WCFS staff, from shelter to middle to executive management, have reported to the OCA that foster care and residential care appear to be unwilling to take children they would have taken before there was a shelter system. As pointed out numerous times to the OCA by WCFS staff, the shelter system cannot say "no" to any child or youth needing placement. If a child, particularly a high-needs child, has a safe shelter placement WCFS report that other systems are slow to create the needed resources for the child. WCFS employees complained to the OCA that historically it was often left to their agency alone to create care alternatives.

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[1] Foster care rates shown are general rates and do not reflect additional child-specific compensation that occurs above those allotted to in the rates.

[2] New rate schedule introduced to reflect the high cost of living in northern Manitoba (Road/No Road access communities), a northern food allowance is built into the rates provided to all foster parents above the 53rd parallel.

The Absorption of Children and Youth from Foster and Residential Care into the Shelter System

WCFS has only recently begun to track foster home breakdown and, because it's early in the process, says that largely this information is preliminary. However the OCA is encouraged that WCFS is now looking at foster care breakdown.

The OCA has found that the majority of children and youth who first enter the shelters have entered from foster care. The OCA cannot determine if children and youth are entering the shelters from general foster homes, high-level foster homes or treatment homes. The OCA would recommend that that agency review the demographic information provided by the OCA about the children and youth in the shelters, specific to those entering from foster care. Further the agency should analyze this information to determine the reason for foster care breakdown which necessitated the shelter admission.

The OCA found that only 8.5 per cent of the children and youth entering the shelters were coming from residential care. WCFS staff interviewed believed that the majority of adolescents 12 to 18 were coming from residential care. The OCA found that younger adolescents age 12 to 15 were coming more often from residential care than other age groups. WCFS staff were asked where they thought children and youth resided before going into shelters. They were allowed to provide multiple answers, which included, home, foster home, another shelter, group home, youth correctional facility, mental health facility or other. The vast majority (60 –64 per cent) of shelter staff stated children and youth were entering in the shelters from residential care (group home, youth correctional or child mental health facilities). When asked the same question 90 per cent of the shelter coordinators report children and youth were primarily entering in from residential and group care.

The OCA questioned DFSH officials if in their opinion children and youth were entering the shelters more often from residential care. The departmental staff interviewed stated that they did not have information that would indicate that children are entering the shelters more often from residential care. When asked if the residential care system was, as the agency believes, unwilling to take the difficult children and youth, DFSH staff replied there was "no proof" that this was occurring.

Throughout the OCA interviews with agency staff (shelter to managers) it was evident that they believe that children and youth are being returned to their care into the shelter system, not only from foster care but also residential care. As well, they believed that children and youth were remaining in the shelter system longer as there are no residential care beds available. Clearly there is a difference of opinion between the DFSH and agency as to how residential care impacts on the EADP system. This difference needs to be addressed, particularly as these two branches now in the same department plan for alternative care resources.

WCFS was unable to provide information about whether children or youth in the shelters for more than 30 days were unable to move because of a shortage of beds in residential care. It would, however, appear that the number of children and youth entering from residential care is not as high as the agency believes.

The OCA is not aware if WCFS and the DFSH currently track residential care breakdowns in the same manner as WCFS is now tracking foster care breakdown. It would be advantageous to the agency if the DFSH began to track all residential care breakdowns across the province.

Placement breakdown will impact on children and youth. Whether that breakdown results in shelter care is not as significant as the impact of that breakdown on the individual child or youth. That impact can often affect a child's placement in the shelters. What the literature tells us is "the more placements a child must endure the greater the negative impact on child development"(Nova Scotia, 2003, p.15). As stated by Agee (1979);

> "Unfortunately, with each new placement several things occur. For one thing the child becomes resistant to establishing new relationships. Secondly, it is harder to find placement for a child who has failed in previous settings. Finally, the child has learned practically foolproof methods of getting out of settings that they do not want to be in". (p.12)

The issue of whether children and youth are coming into the shelter system from foster or residential care is significant but what is more important and requires greater emphasis is the impact of the breakdowns on them. The question of why these placements are breaking down has not been fully addressed by the DFSH or the agency. WCFS is only now beginning to track foster care breakdown. What do we need as a system to do to avoid multiple placement moves for a child or youth? How do we create stability for children and youth? As Stienhauer notes, as cited in Kufeldt (2000),

> "The child who has had multiple placements will have to be exposed to multiple separations and parental figures. With each such separation, the child's sense of lovability, security and stability will be further undermined...Since these children egocentrically assume each such breakdown is their fault, it is not hard to see how their convictions of their inadequacy and unacceptability could be reinforced" (p. 105).

Final thoughts on Foster Care

A WCFS manager, asked by the OCA if the agency was experiencing a shortage of foster homes, said "not every child should or could go to a foster home." Certainly the OCA would agree that children and youth require a continuum of care options. But the shelter system developed and grew to respond to what the agency perceived as a lack of alternative care resources, including foster care. A majority of the children and youth in shelters appear to be entering from foster care.

WCFS appears to believe that foster care is a preferable placement option. According to WCFS, 72 per cent of their children in care live in family-based settings. The literature shows that a successful foster placement is often associated with improved outcomes for some children and youth. As well, literature also suggests that children in less restrictive forms of care fare better as compared to children in restrictive forms of care, such as group care (CWLC, 2003). One younger person (age 13) in the shelter, asked by the OCA why he wanted to live in a foster home as opposed to group care, said:

"A foster home is a place where people will actually care about you."

This young person added he had never been in foster care but had heard about it from other youth in the shelter system that had experienced a foster care placement.

A review of Manitoba's foster care system is beyond the scope of this study. As well, during the AJI-CWI process the foster care system will be examined and changes recommended meeting the needs of the new system as outlined in the DIP. The public needs to know, though, that there is a crisis in our foster care system, as our social workers, childcare staff and foster parents have long believed. Nationally and provincially there is a shortage of foster parents, and most specifically and importantly to Manitoba, a shortage of culturally-appropriate homes.

PART 5: WCFS ORGANIZATIONAL AND ADMINISTRATIVE STRUCTURE AND ITS IMPACT ON CARE

AN EVER CHANGING ENVIRONMENT

WCFS as a service delivery agency has undergone continuous change since the inception of the EAPD system and, more specifically, the shelters. Part 3 of this report reviews the historical development of EAPD and explains the internal and external pressures faced by that system

From 1997 to 2003 the agency experienced massive environmental changes which WCFS staff report affected the agency's ability to concentrate on service issues. Since 1998, there have been:

- four Ministers of the DFSH,
- two Deputy Ministers,
- four major changes to board structure resulting in changing board members,
- four provincial Directors of Child Welfare,
- three Chief Executive Officers,
- two Chief Financial Officers and
- high agency staff turnover at both the supervisory and line levels.

In 2000 the AJI-CWI process began. In 2003 the provincial government absorbed the agency into the DFSH as part of the AJI-CWI process. As well the DFSH began to move towards an Integrated Service Delivery System. WCFS, now a branch of the DFSH, though a stand-alone branch, will eventually be absorbed into the department's Integrated Service Delivery Model.

While the OCA would agree that the AJI-CWI process and other changes were needed, it is clear that constant change can result in a highly uncertain environment. Any organization without effective and consistent leadership has difficulty absorbing and responding to the changes and this can lead to an organizational environment that becomes suspicious and ultimately resistant of change. As stated by one past senior manager;

> **"The environment that the agency operated in was taken over so many times that the agency sees change as a threat as opposed to an opportunity."**

All long-term agency staff members said the constant change particularly in leadership, affected the agency's ability to develop and support the EAPD program in the manner intended. As described by one past senior manager following the 1997 Prairie Research report:

> **"The problem was, that the agency's reorganization plans, coupled with the onset of the AJI-CWI, was that it took away the leadership resources from focussing on service delivery and implementation of the program's management model, and implementing the recommendations of the PR report. The focus of leadership was on other initiatives, not service delivery."**

AN ORGANIZATIONAL CULTURE: RESISTANCE TO CHANGE

Past managers reported that the Agency's reorganization from geographical service areas into Program Management was met with organizational resistance. The agency at that time was still feeling the effects of the 1991 agency amalgamation into four geographical service areas. In essence the agency was operating as four separate agencies under one name and one board. In 1997/98, senior managers saw it as an agency without a clear and comprehensive service strategy. It lacked:

- A unified financial system.
- An agency-wide management information system.
- A community development capacity and accompanying program.
- A quality assurance capacity.

Without these components the agency could never adequately identify the population that required service or the needs of that population. The agency had difficulty convincing the government that it should fund agency plans. As stated by a senior manager involved at the time:

> **"The agency would go to government with anecdotes and government would respond with their own. The agency could never prove its' case."**

Program Management Structure

It was reported to the OCA that EAPD planning was to be completed in conjunction with the agency's larger strategic plan which was developed as the agency reorganized into a program management model.

After the reorganization, management assessed current and future needs relating to emergency beds. The agency tried through its Quality Assurance program to identify their service populations. The agency determined that the primary service target populations were single-parent females, primarily of aboriginal ancestry, living below the poverty line, in substandard housing in high-risk neighbourhoods. The agency's Quality Assurance program was also able to identify specific neighbourhoods where children were more often than not entering into care. The agency determined through an analysis of this information that it required 200 emergency beds.

The agency management was also aware that a number of socio-economic factors contributing to the breakdown of the family were beyond agency control or intervention strategies. The agency management believed that a community development approach needed to be taken in conjunction with the development of long-term community based resources for children and youth. The agency then entered into discussions and partnerships with non-mandated agencies to develop neighbourhood-based foster care resources. As children and youth still required emergency care, EAPD was to "create beds" to meet "cluster of needs" common to groups of children and youth, most specifically sibling groups. EAPD was also charged with the responsibility of creating meaningful programming for residents. Programming was to provide opportunities for exposure to arts, culture, sports and recreation.

It was the hope of agency senior managers that once EAPD was brought under the Resources in Support of Services Program, the program would develop in conjunction with their Quality Assurance and Community Development Programs.

As the agency was completing the reorganization, the use of hotels as alternative care became a focus of management attention. The OCA issued its hotel report and according to agency staff, both past and present, hotels became a political issue. The agency developed an Action Plan by December 2000.

WCFS staff also reported that before 1999 the agency had a conflicted relationship with government and the DFSH. The relationship with government was reported to have improved after 1999 but it was felt that the relationship with the DFSH remained unchanged. As stated by a past senior manager:

> **"This (the Action Plan) was a long-term strategy, not a quick-fix solution. Everyone was looking for the quick-fix solution. The (new) Minister wanted to solve the hotel placement in six months. Every Minister wanted to. Ministers come and go but bureaucrats remain the same. That's the problem, the bureaucrats remained the same and they were unsupportful."**

Costs associated with hotels were rising and the agency continued to post deficits. Funders required greater fiscal accountability, and that led the agency to cut costs. One of the areas targeted to reduce costs was the EAPD system, including hotels. As stated by a senior manager:

> **"They (government/DFSH) wanted us to divert money from emergency placements as opposed to putting money into the plan."**

By 2000 the AJI-CWI process was under way. Senior managers changed, as did the board. The direction of the agency changed and management resources were dedicated to moving the agency into the AJI-CWI process. The Action Plan as provided to the OCA ceased to be operational.

Focussing on 'other initiatives'

But have things changed significantly for the agency from pre-1997 to 2003? The OCA contends that they have not changed greatly. The OCA acknowledges that the agency since 2001 has attempted to respond to shelter system issues. They introduced a project manager to gain greater service control. Once the full ramifications of non-compliance with licensing regulations were understood, the agency worked towards licensing compliance; this remains a work in progress. The DFSH has provided one staff person to assist in the daily operation of the shelters. The addition of this staff person occurred during the OCA's review. The agency, through the project manager, has responded to the majority of concerns raised by the OCA and has shut down shelters the OCA felt were unsuitable for children. The agency has introduced the STEP committee, which is designed to address agency barriers that may emerge in planning for children.

The culture within the organization appears more difficult to address. A conflicted staff/management relationship hampers progress in this area. There is clearly a lack of trust inside the agency about the shelter system; any management effort to effect change is met with suspicion. In the background there still appears to exist, at times, an adversarial relationship with the DFSH. Current managers felt the DFSH abandoned them in efforts to resolve the resource crisis, and then blamed the agency for the high costs of the shelter system.

The problems in the EAPD program reported to have existed before 1997 appear to still plague the agency today.

DIVERTED LEADERSHIP

As the EAPD program continued to develop, agency executive managers changed and senior managers' time and attention were demanded by agency reorganization, program management implementation, development of the Action Plan, AJI-CWI and then to the absorption of the agency into the DFSH. As a result it was reported to the OCA that managers time and attention was diverted from the EAPD program and its ongoing development. The continued development of the program was left to the EAPD supervisors (past and present) and coordinators. The lack of overall co-ordination and direction from executive management allowed the program to drift.

A clear example of this was the licensing of shelters after the 1999 changes to *The Child and Family Services Act*. When the OCA questioned past and current managers as to why the shelters were unlicensed no one could adequately respond. Managers did state that they were aware that the new act was coming into force and between 1998 and 1999 the program supervisor was communicating with the DFSH. They assumed the process was continuing towards compliance. However, as stated by one past manager, "about half way through 'shit hit the fan' and the big push to licensing happened over night." Agency board and executive management appeared not only ill-prepared but also unaware, as the costs associated with licensing were never a past budgetary consideration. It would appear that the board and executive managers relied on program manager who in turn relied on the EAPD supervisor(s) to address this issue. Potential liability and cost ramifications associated with licensing was never fully understood by the agency's leadership. The leadership was apparently unaware that to circumvent zoning bylaws agency staff moved to reduce shelters from four beds to three.

This lack of leadership and direction had a direct and negative impact on the EAPD program development. The expansion of EAPD was driven by the crisis in developing and securing alternate care resources. EAPD was charged to respond to this crisis, and as clearly stated by WCFS staff interviewed, EAPD was a program that could not say no. The program developed in a reactionary manner to the crisis. Eventually the administrative approach became characteristic of that crisis, as was evident in the EAPD policies and procedures. Before 2001 policies and procedures appeared to also be developed in a reactionary manner, often to specific incidents. After 2001 the agency attempted to amalgamate the policies and procedures, but these still appear to fall short of what is required.

EAPD was clearly a program under tremendous pressure to meet the resource needs of the agency. As stated by one current senior manager the EAPD program and ultimate response was "crisis driven." There was simply no time for the program staff and supervisors to plan. As one past manager stated to the OCA:

> **"It was crisis management without management realizing there was a crisis."**

Agency managers appeared to quickly adopt this "crisis-driven approach" as it related to the EAPD program development. The OCA questioned one senior agency manager why, after 1999, EAPD had not developed a detailed program statement reflective of the criteria required under current licensing regulations, the manager responded:

> **"I don't know. However, we have to respond on an as-needs basis. What are we supposed to do, shut it down to write a program? We cannot say no to kids. Residential care can say no and do say no but the kids still need a bed. Those are the questions that have not been asked."**

The need for emergency placements continued to pressure the agency, and the costs associated with EAPD shelter system continued to rise. By 2000-2001 the agency moved away from its action plan because of "a re-prioritization of issues identified by executive management," primarily cost containment and fiscal accountability.[1]

THE LACK OF PROGRAM EVALUATIONS

As part of the agency's reorganization, EAPD development was to be connected to the Quality Assurance program. The Quality Assurance program was to "have the lead responsibility for service reviews, program research and evaluation, policy analysis, co-ordination of response to external reviews, and agency risk management" (WCFS 1999:24). This was a vital connection that was never fully realized. Had it been implemented, the agency could have better developed and evaluated the EAPD program.

When the OCA started this review, we asked to be provided with any program evaluations or reviews conducted by the agency with respect to EAPD and or the shelter system. Beyond one report prepared in 2001, which was not a program evaluation, the OCA discovered that there were no program evaluations or reviews completed. The OCA asked all current managers if there were any needs assessments, program evaluations, and/or cost analyses. Categorically the answer was no. As well no current manager or staff person interviewed described the process the agency went through in 1997-98 in determining the number of emergency beds required, or the process that led to development of the action plan. It would appear that the agency continued to 'develop' a program without evaluating the impact, effectiveness or outcome (intended or unintended) of the program.

Program evaluations, though not a panacea, can have a considerable impact on policy development and program design. Effective communication must exist among the various groups concerned; board and senior managers, line managers, staff and program clients must be involved substantially in the evaluation process. No such process has occurred in the agency with respect to the EAPD-Shelter system.

Continued Struggles with Population and Problem Identification

Before its reorganization the agency could not identify the population it served or the needs of that population in an effective manner. When conducting this review, the OCA could never get a clear description of the overall population in the shelters. Who were these children, Where were they coming from? Where were they going? What were their needs? Many told the OCA that they believed the children served were primarily adolescents, others thought younger school- age children, and others reported younger children inclusive of babies. We were told that children were primarily coming from their familial homes and exiting the shelters quickly. Others suggested that the shelters were serving primarily adolescents coming from high-level foster care and or residential care. Still others suggested that the shelters were the alternative to hotels.

The agency, as it did in 1997, still struggles today to produce information that would effectively identify its service population and/or need. It would appear that the agency relied too heavily on descriptive case-specific information in the development of the EAPD program. As a result the agency concentrated on short-term case-specific issues to the exclusion of longer-term issues and development of appropriate alternatives. They quickly developed 'tunnel vision' in their understanding of the population the shelters were serving and in their attempts to create alternatives to shelters as can be clearly seen in the agency's Consolidation Plan.

Without knowing the problem or the service population and their needs, the agency also could never adequately prove its case to its funders.

Financial Management: Please see Part 7, **The Costs of Care**

THE LACK OF OWNERSHIP

What became sadly evident throughout this review was the perceived lack of ownership and ultimately accountability of agency management for the shelter system. The shelter system after 2001 was viewed as a problem created by others. The task of 2001 interim board and management was to fix the problems and curtail the costs. This task now falls to the DFSH.

The OCA wanted to review the agency's 'corporate history' and decision-making process regarding development of the EAPD system. The OCA quickly discovered that no such information existed inside the agency, or if it did no one knew where it was. The OCA had to, through extensive interviews of current and past staff, pieced together the history of the shelter system. The original shelter system and its resulting collective agreement were developed on a foster care model. The program's drift to a residential care model changed the operational environment of the shelters. The necessary administrative supports required to support a residential care model did not exist inside WCFS.

The clearest example of this shortfall was the lack of supervision in the shelters. Shelter coordinators work during regular agency hours and cannot supervise all shifts. Shelter coordinators are housed in an agency office and not in the shelters, making them at times inaccessible to the shelter staff.

Human Resource support was centralized to head office and not accessible to the shelter coordinators in a proactive manner. Shelter coordinators with little training in the implementation of the collective agreement were required to ensure its implementation and interpret its articles often in isolation from the agency's Human Resource Program.

The overwhelming response to the OCA questions about the development of the EAPD system was to blame and deflect. Current managers could not answer questions about the daily administrative operation of the shelters but referred the OCA to others who "would know." These others were inevitably subordinate staff. They left the impression that the problems as defined by agency managers were isolated to the shelter staff and coordinators. Staff needed to be better trained, yet the agency provides few opportunities for training. The shelter system was deemed to be a short-term solution and staff temporary. Staff and coordinators were treated accordingly and after 2001 were told staff would be re-deployed and coordinators laid off. Though the agency recognized that the nature of the work tended to isolate staff members, it provided few opportunities to bring staff into the organizational community.

THE UNCERTAIN FUTURE DIRECTION

It would appear that the majority of shelter staff employed by the agency did not understand the purpose of their work in context to the larger purpose and direction of WCFS. The OCA asked shelter staff how the EAPD system fit into the agency's larger mission, vision, purpose and ultimately service direction. We found that:

- The majority of shelter staff could identify that EAPD was to provide emergency short-term care.
- Conversely the majority of shelter staff could not identify the overall service vision of the WCFS and how EAPD fit into the larger agency's service vision and model.
- The majority of shelter staff did not possess a basic understanding of the role of WCFS, the agency mandate under the act or the agency structure.
- Shelter coordinators, middle and senior managers were well aware of the purpose and nature of their work in context to the larger purpose and mandate of the agency.

The direction of the agency as it relates to the EAPD system was unclear to the shelter staff. As well, there was general uncertainty on the part of the coordinators about the future direction of the EAPD system. Many of their recommendations for the future were focussed on the administrative operation of a shelter system delivered inside the current organizational structure of WCFS.

The OCA asked to be provided with any business and or strategic plans associated with the historical EAPD-shelter system, the current system and prospective future direction. We were told none existed beyond the Consolidation Plan, which was designed to create community-based alternatives by diverting resources from the EAPD system. The future direction of the EAPD system appears to be stalled in the uncertainty of the agency's current organizational environment. When managers were asked if there were strategic or business plans that would outline the future direction of the EAPD system, we again met with uncertainty. We were told:

- "We can't do anything because of the contract."
- "The AJI-CWI process will take care of this."
- "We are going into government so many of the problems will be taken care of by them."

During this review the OCA did request that the agency not create six- and or eight-bed shelters. We were concerned that the move to do so was primarily based on financial considerations as opposed to effectiveness of service delivery and a clear understanding of the population that required such service. The OCA did not request that the agency stop its efforts to develop plans for the future resource development for the agency. As well, the OCA understands that the agency and the DFSH continue in their efforts to develop alternative resources to the shelters.

The OCA was certainly aware that agency managers might have chosen not to share information about the future direction of the EAPD system coupled with their strategies for resource development. Their discussion and planning may be confined to the DFSH. Future planning will, however, be difficult if planning remains isolated to senior officials inside the agency and DFSH.

THE INTERNAL SERVICE CO-ORDINATION AND ITS IMPACT ON CARE

Policies and Procedures

The EAPD Home Manual

EAPD was to provide "superior transitional care and protection to children" while ensuring their needs were met through a safe, nurturing environment through assessment, planning and innovative programming."[2] But when it moved from its foster care model toward a shift staff, residential care model, problems quickly arose concerning administrative procedures, child management practices and the roles, responsibilities and conduct of staff, particularly as purchased-service staff were employed. Practices appeared to vary among the shelters; standardization was required. The Home Manual was created. The Home Manual was to outline the day-to-day operation of the shelters, including child management practices, and outline the agency's human resource policies and procedures.

The Absence of a Program Model

The development of the EAPD policies and procedures, which eventually culminated in the Home Manual, took place in absence of a defined program model. Originally the policies and procedures "piggy-backed" onto the foster care licensing, regulations and standards. As the operational environment changed, moving from single caregiver to shift staff, these policies and procedures no longer fit the model. EAPD, required now to respond to the needs of any and all children and youth requiring emergency care, operated within increasingly impermanent programmatic boundaries. As a result, EAPD did not develop or articulate a program model, which defined its goals and objectives, resources, program activities and/or outcomes. A program model should define and articulate the organization's actions in providing emergency care. Policies and procedures intended to guide staff in carrying out these actions were developed in absence of a clear definition or direction of these actions.

Reactionary Policies and Procedures

EAPD managers began to address problems by developing a series of reactionary policies. These policies dictated not only child care practices of staff but attempted to address human resource issues if the procedure employed by staff varied from the initial policy. An example was the Movie Privileges Policy. On the surface this policy was developed to deal with what appeared to be an issue inconsequential to the daily operation of a shelter and one based on sound child management practices.

In May of 1999 some complaints were made to an EAPD supervisor that child care staff were taking children and youth to age inappropriate movies and playing inappropriate video games. The supervisor developed the Movie Privileges Policy, which required EAPD workers to receive prior authorization from the EAPD supervisor, shelter coordinator, or child's foster parent or program worker. Failure to do would be considered a performance issue and dealt with accordingly.

Such reactionary policies quickly created a reaction. Shelter staff fearing disciplinary action now mistakenly thought they needed to check out all activities not only with EAPD managers but also with the child's social worker. Though the movie policy was changed in November 1999 and removed the threat of disciplinary action, the lesson to staff remained.

In the OCA interviews with staff and union officials, the OCA was informed that shelter staff had over the years lost their autonomy to plan for children. Reactionary policies were seen as the root cause. As stated by one shelter employee:

> **"You have to check with the social worker on everything. So if little Johnny wants to go to a birthday party or an outing with other shelter kids, you have to check with each child's social worker. If the answer is no or you miss one social worker, then little Johnny and the other kids don't get to go. It's a lot easier to do nothing."**

It would appear that as problems emerged EAPD would create a policy, procedure or protocol to solve the problem. Fairly straightforward and commonsense child management issues that would normally be dealt with by a trained and competent staff were now formulated into "policies." As stated by one WCFS manager,

> **"EAPD is big on rules, so their policies and procedures are really a list of do's and don'ts. They offer very little in terms of best practice and procedures."**

The Lack of Consistent Training in Policies and Procedures

The introduction and training in new policies and procedures was to be completed by the shelter coordinators. Shelter coordinators were asked whether shelter staff was provided with additional and refresher training in the EAPD Home Manual. Forty-five per cent said yes. However, 54 per cent responded that additional or refresher training was not provided to staff because of time and funding constraints. The latter group of coordinators explained that there was not sufficient time spent on training and that staff would only receive training if new policies and procedures were being put into action. Effective and consistent communication between coordinators and staff and supervision of staff across all shifts was problematic (see labour relations section). As a result, training about new policies and procedures was inconsistent and at times did not occur.

As the EAPD system grew, so did the need for staff. The agency felt it "could not hire fast enough" to keep up with the growth of the shelters and the volume of children and youth. The shelters often needed to supplement shifts with purchased-service staff.

The agency's obligation to train these staff was not clearly stipulated. It was reported to the OCA that historically the hiring process for shelter staff was predominantly "word of mouth" with limited advertising.3 Typically a three-hour orientation was held for interested people. The information session included information about the position, the agency, the skills required, including building trust with children, working as a team member, providing consistent care and the appropriate discipline of children. Those selected for interviews through the orientation process were then moved to the next level of recruitment. Once hired, the individuals completed all of the necessary checks (PCAR, police and references) and were provided another orientation, but now as new staff. This training was limited to administrative training and an overview of the existing policy and procedures. No further training in policies and procedures was offered except as new policies were created.

Keeping the Home Manual Updated

The OCA was told that as new policies developed, training was provided. However, this assertion was in stark contrast with the agency's actions in keeping the Home Manual updated to include new policies and procedures and evaluating the effectiveness of those policies and procedures. Policies and procedures were developed in a "top down" approach, coming from "head office." No mechanism was provided to gain staff input or feedback about the implementation and ultimate effectiveness of the policies and procedures.

The WCFS management held the view and expectation that not only were shelter coordinators responsible for ensuring that the Home Manual was updated, but also they were responsible for the training needs of the shelter staff. Managers also stated that shelter coordinators were responsible for implementation and staff compliance with the Home Manual. Asked who was responsible for implementation, 26 per cent of staff coordinators responded that coordinators and staff were responsible. Eighteen per cent stated it was the EAPD supervisor and coordinator's role. Twenty-two per cent felt it was the coordinator's role to implement. Four per cent stated it was the agency as a whole that was responsible and four per cent felt no one was responsible for the implementation of policy and procedures.

Coordinators were unclear when they were asked who was responsible for evaluating the Home Manual effectiveness. Their lack of clarity was compounded by the fact that the EAPD Supervisor's position had been vacant for more than a year at the time of the Shelter Review. Shelter staff reported:

> **"I don't think anybody does it but it should be our supervisor."**
>
> **"The shelter supervisor but we have not had one so it has not been evaluated."**
>
> **"Staff, coordinator, supervisor of EAPD are to assess. The supervisor has to be updated and must approve."**
>
> **"EAPD supervisor and coordinator with input of staff."**

The reactionary development and the inconsistent communication of policy and procedures and the lack of follow-up training created a number of problems with consistent implementation of the policies and procedures.

Inconsistent Implementation

It became clear that there were many conflicting and inconsistent practices and attitudes surrounding the Home Manual throughout the agency. Past and present managers had differing opinions about the manual. Some believed the Home Manual was to provide the operational policies and procedures; others believed that the manual was simply a "set of rules" not reflective of either best practices or licensing regulations.

Some of the comments made to the OCA about the Home Manual from staff and coordinators included:

> **"It is outdated. No one is responsible for keeping it up."**
>
> **"Fifty-two pages of policies but each shelter has their own rules."**

"Doesn't provide operating structure, it provides rules and guidelines that tell staff what to do when something happens or how to respond."

The Impact on Care

The OCA found that shelter staff viewed the Home Manual in attitude and practice as nothing more than guidelines, and that it was often interpreted differently among shelters. Coordinators and managers thought the Home Manual was outdated and did not reflect best practices. Consequently the shelter staff lacked the concrete direction and support to be consistent in the implementation of policies and procedures and therefore at times are unable to maintain effectively the day-to-day operational functions of the shelters in specific areas. Structure and routine become problematic not only for the staff but more specifically for the children and youth.

Social workers were also interviewed by the OCA through a voluntary focus group comprised of a representation of service units throughout the agency. As well those units who could not send a representative were invited to send their answers to the focus group questions in writing. All were provided with the focus group questions in advance of the meeting. Feedback from this staff group indicate that many felt EAPD policies were consistently changing, causing confusion among the social work staff and at times negatively impacting on children and youth. An example provided involved apparent policies surrounding family contact and telephone use by children or youth. One social worker stated that in one case, the agency provided the child's mother with the shelter phone number to encourage and support contact. The social worker did not know that the child was not allowed to use the phone given that particular shelter staff's interpretation of the rules. Social workers also commented on the inconsistencies between the shelters of policy implementation. As well, they pointed out that different shelters do "different things" and even that individuals at a shelter would implement policies in different ways from other staff at the same shelter.

The agency's overall responsibility was to ensure that clear, concise policy and procedures were created, and that these policies reflected and articulated how emergency care would be provided to children and youth. Section 28.1 of the *Child Care Facilities Licensing Manual and Child Care Facilities Licensing Regulations* describes in detail the categories of required policy and procedures. Once licensing became the over-riding concern of the agency, they did in 2001 attempt to revise their policies and procedures. The agency, however, still encountered difficulties establishing consistent training and supervision of staff with respect to implementation, evaluation of and maintaining the Home Manual.

Roles and Responsibilities

The Home Manual and the *Child Care Facilities Licensing Manual* provide a guide for specific processes for case planning for children within the EAPD shelter system. The Home Manual provides a checklist form for each child admitted or discharged from the shelter facility. These checklists are to assist staff in assuring appropriate documentation concerning the child is received, or forwarded, and all necessary appointments have been scheduled. The EAPD shelter system also prescribes basic assessments of individual children and their needs while they are in shelter care. However, no policies or manuals contain detailed descriptions of what is expected within admission and discharge conferences, assessment formats or who is responsible for completing them.

Admissions Process

The most pertinent information that would assist shelter staff in providing care for a child is located within the admission checklist form. This form encompasses necessary demographic, medical and case-specific information about the child. However, the completion of this information is dependent upon the information available at the time that the child enters the facility. The accuracy and consistency of this process is dependent upon who transports the child to the shelter. Shelter workers report that children are not always admitted by the assigned worker, but are more frequently admitted by agency after-hours workers and hotel support workers who typically have very little information about a child. The quality of information obtained is also affected by the type of staff working the shift within the shelter. Further, some shelter staff report not feeling empowered to contact the assigned worker directly to obtain child specific information, as this is seen by some as the responsibility of the shelter coordinator. The confusion surrounding responsibility is exacerbated by the lack of formal written procedures that outline the admission process. As stated by WCFS staff and coordinators:

> **"During the admission process, someone drops off the child and some clothes, maybe some log notes, information is minimal as we seldom get proper birthdays or spelling of names."**
>
> **"Admission forms are completed with as much information as possible, we check the clothing needs, general state of health, make medical appointments and document any concerns."**

EAPD recognized the need to address issues of inconsistency in the information. The department also recognized that the administrative process of case assignments to social workers also presented a delay in obtaining relevant information from the assigned worker. EAPD began to implement the use of an admission conference among the shelter coordinator, shelter, social worker, and where appropriate the child. Every coordinator interviewed reported that these conferences occur within the first seven days of a child's placement in shelter.

But confusion continues about who is responsible for setting up the conferences. Only 54 per cent of shelter coordinators state that the admission conference includes the social worker, coordinator and shelter worker. Other coordinators commented that admission conferences usually occur over the phone, as it is difficult for workers to attend, while others indicate the conference occurs between the shelter worker and the child. Social workers reported that it is the responsibility of the coordinator to facilitate the admission conference.

Another factor impacting on the admission conference concerns the type of information shared about children and youth within the shelter. Some social workers report reluctance to share child specific file information with the shelter because of confidentiality issues. In some instances, a social worker will provide the shelter the child's social history, while in other situations, the social history will be shared verbally with the coordinator who is then expected to pass the information on to shelter staff. Unfortunately, the nature of care by shift staff does not always lend itself to the equal sharing of information to all those charged with providing care for the child.

> **" The case manager is responsible for all the information pertaining to the child and the family, the planning strategies, supports and notification to collaterals. Information is then shared with the shelter coordinator and they relay the information onto the shelter workers."**

> **"There is a definite need to outline the roles and responsibilities of shelter workers, coordinators and social workers. Inconsistent arrangements occur with admission and case conferences."**
>
> **"Shelter coordinators should be able to glean and discern what type of information within a social history gets shared with shelter staff. This is a huge issue of confidentiality"**

Assessments

Basic functional assessments of children's and youth's daily needs were intended to be an integral component of the EAPD shelter system. These assessments were to assist workers in obtaining information about a child/youth's daily functioning to assist social workers with locating an appropriate placement resource. Interviews with agency managers revealed considerable discrepancy over who completes assessments in the shelter, and what type of assessments are completed - if any at all. Some managers believed that assessments were to examine a child's day to day behaviour and functioning, while others stated that assessments do not take place at all. All managers stated that there was no model or format for these assessments.

> **"Coordinators are to assist shelter workers in gathering information about a child, and to help shelter staff determine what is a concerning behavior for a child. They are to be a liaison for information to and from the social worker."**
>
> **"Shelter staff are only able to assess basic stuff that looks at a child's behaviour"**
>
> **"The shelters do not have an assessment function, we are hoping this will come with a new supervisor assisting coordinators in this area"**

While coordinators and shelter workers agree that assessments are part of their function within the shelter, they are inconsistent regarding who is responsible for doing them. Shelter coordinators indicate assessments on a child's daily functioning, response to environment, and behaviours are all areas that are documented and forwarded to the social worker. Coordinators and shelter workers complete these assessments. However, shelter coordinators and staff report that they have never been provided with any training from the agency in assessment models, and those who have had prior knowledge, have received it through their own post secondary education. Overall, shelter coordinators and staff indicate that they have the skills to make observations, but not to conduct formal assessments. Consequently, they feel more training is required in this area in order to be effective.

> **"All staff, including coordinators need to have training in assessment models."**
>
> **"Many children and youth are not properly assessed due to the lack of training."**

Discharge Process

Similar to the admission process, the discharge process should include a checklist of a child's belongings and the forwarding of all log information to a child's case manager. In situations where a child may be moved within the EAPD system, shelter staff may complete a summary of their stay at the shelter. Agency executive managers indicate that when possible, a planned discharge conference should occur when a child is leaving the shelter. However, coordinators and shelter staff indicated that discharge conferences are an anomaly, as there are no formal written procedures that outline this process.

Interviews with shelter coordinators and staff reveal that only occasionally are there opportunities for youth to participate in pre-placement visits to their new placement before discharge from the shelter. The shelter staff indicate they would prefer to plan and assist a child for discharge from the shelter, but notification of discharge is often with little notice. Often shelter workers and coordinators receive just enough notice to complete the checklist, and pack all the child/youth's belongings in a garbage bag.

> **"Pre-placement visits should be provided prior to discharge. They should be planned in relation to the needs of the child, and should be consistent."**
>
> **"It would be nice to give kids notice about where they are going, and to give them an opportunity to visit their new placement. This would help to ensure the viability of future placement, and reduce breakdown."**
>
> **"It would be nice to have a discharge process written in stone. But this could be very difficult because we are emergency and temporary placements.**

PART 6: STANDARDS AND BEHAVIORAL COMPLIANCE

DFSH – Licensing Requirements

The DFSH is responsible for licensing the EAPD shelter system. The shelter system operated for four years before changes in legislation required compliance with *Residential Care Licensing*. To expedite the licensing process of the pre-existing shelters, the DFSH provided a level of latitude to the agency in the licensing process. Had the facilities been required to qualify for licenses at the outset, the level of scrutiny would have been higher.

EAPD facilities operated under a mission statement and program statement that were vague in describing the program's purpose and function. The DFSH took the position that their priority was to ensure all facilities caring for children operated under a license. The licensing process focussed primarily on building codes, structures, and certain components within a child's log file. As a result, the DFSH was less concerned about other licensing requirements such as program goals, need for the facility, services provided, a description of the client population needs, or whether the EAPD program description was reflective of the program characteristics outlined in the *Residential Care Licensing Standards and Regulations*.

The EAPD program descriptions provided information on the age ranges of children and youth that were to be served within the shelter system. EAPD was licensed within two age groups: 0-11 and 12-17+. The wide age ranges do not lend themselves to implementation of structured programs including school and community participation, developmentally appropriate household rules, structured recreational activity nor formalized programs or assessments that could be completed within this environment.

EAPD can apply to DFSH to alter the age configuration of their shelter, or for permission for a primary caregiver to sleep during a shift. The agency provides a rationale for the request to demonstrate to DFSH that the care of the children would be maximized by the implementation of the variance. Often, these variances accommodate sibling groups where one or more siblings may exceed the maximum age of 11 in a license. Variances can also accommodate care for young children, under the age of 11, by allowing 24-hour care by the primary caregiver. The variance allows the care giver to sleep during their 24 hour shift, in the interests of providing continuity of care and thereby reducing the number of caregivers in the home. However, the variance process does not require an inspection of the home, nor knowledge or consent from the child's worker to agree to the rationale provided for the variance request.

The licensing process also ensures that staff employed within any residential care facility must possess minimum qualifications of First Aid, CPR, and NVCI certifications, and attendance at a formal orientation. The DFSH reports that at the time of licensing in 1999, many EAPD staff did not have current certifications in these minimum qualifications, nor was formal orientation offered to the staff before their first shift. As part of the annual licensing review, the DFSH Licensing Coordinator reviews staff lists and ensures that all staff working within the shelter possesses the necessary current certifications. However, the DFSH Licensing Coordinator has no jurisdiction to ensure that staff provided through purchased-service agencies possess these same certifications, and receive an orientation specific to the EAPD shelter facilities.

Interviews with DFSH staff reveal that the downfall of the licensing process is that it fails to speak to the issues of quality. Licensing standards and regulations are intended to operate as minimal guidelines that guide service. Quality of the home environment, log documentation, staff skill levels, programming and recreational opportunities are all left to the interpretation of the individual EAPD coordinators and managers. However, there is no recourse for the DFSH to ensure that individual care facilities exceed minimum expectations. The DFSH employs one staff person to license all residential care facilities in the province. That same person also issues variances and supports residential facilities in striving to create and maximize service goals. At the current time, one staff member is insufficient to complete all annual reviews, variances, and provide support to these care facilities. In order to better serve children in residential care facilities, the DFSH Licensing Standards and Regulations should require ongoing compliance of facilities, not just at the time of annual reviews.

Incident Reporting and Analysis

Incident Reports are used to report issues of concern to a CFS agency and licensing authority (DFSH) occurring in a licensed child care facility respecting residents, staff and community. An "incident" is defined under *The Child Care Facilities (Other than Foster Homes) Licensing Regulations* section 34(1) as:

- "A serious illness or change in resident's health;
- A serious accident involving a resident;
- An error in administering a prescribed medication to a resident or an adverse reaction by a resident to medication;
- Abuse or the danger of abuse of a resident;
- The death of a resident; or
- In addition…any other serious occurrence which takes place which may affect the health, safety or life of a resident or another person" (p. 35).

The Child Care Facilities Licensing and Standards Manual adds that an incident can be interpreted as:

- "Any serious licensing standards violation including all incidents of abuse (physical, verbal, emotional, psychological, financial), medication errors, medication or chemical abuse.
- All fire incidents.
- All incidents resulting from defective physical structures.
- Any emergency situation which involves a child in care and police intervention (excluding AWLs, unless of a serious nature).
- Any emergency situation which involves public health or medical intervention.
- Any situation in which a care provider or other adult in the home is charged under the Criminal Code of Canada" (p. 73).

The purpose of an Incident Report is first to ensure licensing requirements are met with respect to child safety and child management. Secondly, incident reports document and track patterns of behaviours either on the part of the child resident or the adult staff. Thirdly, they are to ensure any incident is reviewed to "ascertain the circumstances and factors surrounding the incident and to institute corrective measures as may be required to prevent a similar incident in the future" (*The Child Care Facilities Licensing Regulations* section 34(2) (c) (p. 35).

All residential child care facilities are required to comply with licensing regulations, and when an incident occurs to notify the Provincial Director of Child and Family Services[1] (the licensing authority) within 24 hours. In situations where a staff person has allegedly abused a resident, the placing or guardian agency must also be notified. An Incident Report is then completed by the staff person involved and submitted within five working days. A copy of the report is sent to the Licensing Authority and the affected child's guardian or placing agency. As shelters are considered licensed childcare facilities, they are compelled to comply with these standards.

The shelters are also required to follow WCFS internal policies.[2] These outline the process and require the shelter staff on duty at the time of the incident to fill out the Incident Report and forward it to their shelter co-ordinator. The shelter staff is also required to document the incident in the shelter logs (staff and child).

The shelter coordinator then reviews and submits the incident report to the supervisor. Because the supervisory position was vacant during the time of this review, Incident Reports were sent to the Project Manager in charge of consolidation. The Project Manager reviews the report, signs it off and gives it back to the shelter coordinator who then sends a copy to the resident's social worker. A second copy is kept on the shelter administrative file. The Project Manager also forwards a copy, or instructs the shelter coordinator to forward a copy, of the incident report to the DFSH Licensing Registrar. The timelines of this process are to be immediate, within one working day of receiving the report.

Throughout this process there is to be a quality assurance safety net, in that the coordinator is to ensure its accuracy. If required, they also ensure there is follow up with the child, shelter staff, the child's social workers and identified community resources, including the DFSH. The shelter coordinator, supervisor or Project Manager also ensures that the child's social worker and the Licensing Registrar are immediately made aware of the incident. All Incident Reports are to be documented and the necessary authorities are to be made aware of the incidents.

The benefits of incident reporting are obvious. First and foremost, safety of children and youth can be secured. Patterns of child, staff or facility issues can be tracked, assessed and plans developed to correct the issues. The Licensing Authority (DFSH) is notified and can monitor actions taken and also determine and assess patterns of child, staff or facility-related issues. The DFSH can intervene and offer support, resources and direction, thereby ensuring that not only are the licensing standards met but also that residential care facilities can meet the needs of the individual child or youth.

WCFS can use Incident Reports to document and track child management techniques employed by their staff. Intervention can occur from a human resource perspective to provide additional supervision, support and training for staff. The collection and tracking can also assist WCFS in determining requirements in particular shelters. If there is a pattern to incidents in a shelter at a given time or with a certain population of residents, staff can be added to support care and to help avoid incidents. Immediately informing a child's worker of a child's behaviours and or needs can assist the social worker in planning for the child and their future placement needs.

The Current Practice of Incident Reporting

What became very clear to the OCA following our interviews with union officials, WCFS staff and management and officials from the DFSH is that the practice of incident reporting was very different from the stated policies governing this process.

A general theme that emerged from our interviews was a lack of compliance in reporting incidents. The confusion and resulting non-compliance appeared anchored on disagreement of what would constitute an incident and the purpose of reporting such an incident.

Shelter staff, coordinators and management of WCFS either could not clearly identify what constitutes an incident and or there appeared to be a difference of opinion on what each group identifies as reportable incidents. The current forms used by the DFSH add to this confusion. The definitions of "types of incidents" are fairly broad and would require training of staff and supporting internal policies to ensure uniformity in identifying and coding incidents appropriately. This does not occur in WCFS. As a result incidents are not consistently and uniformly reported. As stated by one WCFS manager when asked about the provincial incident reports:

> **"The range of reportable behaviours is amazing, from AWOLS to death of a child, so as a result no one fills them out."**

The OCA found three primary examples, which demonstrate the problems surrounding definitions of incidents.

Physical Assaults and Aggression

Physical assaults and aggression are behaviours that must be reported to the province and within the agency. There are currently six categories under the Assault/Aggression incident type in the provincial Incident report. One is "resident to resident" and refers to an assault of one resident by another resident. When asked to describe resident-on-resident violence, staff often misidentified types of aggression that would not or should not be considered "physical assault" when one considers the range of aggressive behaviour found in a population of children that are developmentally at certain stages. Staff misidentification of incidents was confirmed through OCA interviews with shelter coordinators and WCFS managers. This was particularly true when one considers younger children placed in the shelter who find themselves in unfamiliar circumstances separated from parents, siblings and community and who are likely experiencing high levels of stress. These children may react aggressively but that aggression would not necessarily be considered outside the normal ranges of a child's developmental response to stress.

Some staff, for example, identified a toddler biting staff or a same age child resident as a "physical assault." Seventy-two per cent of the staff interviewed by the OCA responded that they had been assaulted by a resident. Twenty per cent of these staff identified being bitten by a child as being assaulted. Such identification and possible reporting can begin a pattern of labeling a child or youth whose behaviour certainly is aggressive is within a typical response range for their age grouping. The danger of such reporting is that these labels are passed on in our system and can affect a child's future placement possibilities.

Shelter staff and coordinators also often disagreed over what incidents should be reported. At times, coordinators reported going back to the staff person who had 'misidentified' an incident. When such disagreements occurred, coordinators and managers were often accused of not paying attention to child or staff safety issues or at times not filing the incident report.[3] As stated by one WCFS manager:

> **"Staff do not know what a reportable behaviour is, for example is it a reportable incident if a four-year-old hits another four-year old....Coordinators are also unaware of what an incident really is, so at times they do not file. Shelter staff and coordinators are confused as to what is normal child behaviour and what is extraordinary behaviour that is to be reported."**

The Use of Isolation and Seclusion

Licensing standards require that all incidents where children or youth are placed in "seclusion/quiet room" in order to stabilize/manage behaviour be reported to the DFSH and the child's guardian and placing agency. Further, any child care facility using an isolation or quiet room must have prior written approval from the Director of Child and Family Services. The room used must be so designated by the director and used for that purpose only. Children and youth cannot be placed in isolation for more than two hours at a time and are to be checked on at five-minute intervals. The isolated child must be within sight/hearing of an adult. Isolation cannot to be used as punishment but used only to ensure a child's or others' safety.

In a review of the shelters incident reports[4] (n=957) use of isolation was reported to have occurred in only one per cent of the reported incidents from 2001 to 2003. Isolation as described in licensing standards cannot be implemented in the shelters. The shelters do not have designated and approved rooms and therefore have no internal policies regulating staff use of isolation as a behaviour management technique.

In OCA staff interviews 64 per cent of the staff report using isolation as a behaviour management technique. What the staff are referring to would be considered seclusion or "time out" of the child or youth, such as the separation of a child or youth involuntarily from the other residents and placing in an unlocked room or area. Staff confirmed children and youth are being secluded to common areas and or bedrooms and can be required to stay in the room for extended periods of time. There appears to be no guidelines for staff to implement seclusion or "time out" practices beyond that they are allowed to use "time outs". Provincial licensing standards do not speak to the use of seclusion and therefore cannot be adequately documented or tracked by either the agency or the DFSH.

Medical Errors

Another category of incident type found in the provincial Incident Report, is "Medical" which includes only two sub-categories. The first, Hospital or MD is to be used to record all "accidents involving injury to a resident, which requires medical follow up and intervention." The second category is medication error - "an incident as defined in the medical policy." The OCA generally found this category used for younger children ages 0 to 11. However, we found in many incidents a medication error was recorded but there was little accompanying information to determine what the medication error was. Over-medicating a child, under-medicating, or giving the wrong medication could potentially have serious consequences for a child. WCFS does have medical policies in the Home Manual but these appear to focus on actions staff must take when a child requires medical attention and the logging of when staff dispense prescription or non-prescription medication.

When Staff Contribute to and/or Cause the Incident

As stated the OCA found there was general non-compliance to the reporting of incidents. This appears to be a very real problem when shelter staff believe that another staff person may have caused or contributed to an incident. The current Incident Report allows for the reporting of allegations of abuse made against a current or former staff or incident only where employees are charged under the Criminal Code. Staff behaviour that may have negatively impacted on residents or other staff and may have contributed to an "incident" cannot be documented using the current Incident Report format. In OCA interviews the majority of staff (88 per cent) did indicate that they report incidents, when a child or youth are identified as the aggressor. When the aggressor in an incident was identified as another staff, only 58 per cent of the shelter staff reported the incident to their coordinators and then did so only verbally.[5]

WCFS managers reported they do not track Incident Reports that document staff issues or environmental issues related to the shelters. Incident Reports outlining staff behaviours were not routinely sent to the agency's Human Resource Department, as the Incident Reports are not meant to capture such information[6].

In addition, there appears to be no formal mechanism in place for the agency to routinely report back to employees who have filed an Incident report. Staff and union officials both reported that they have stopped reporting many incidents "as nothing ever happens" to address the issues reported. They stated that it is very rare that a child's social worker comes to address the issues reported. Shelter staff attributed this to social workers' high caseloads. Shelter staff report being frustrated with the lack of feedback from shelter coordinators and agency managers.

Once an Incident Report is sent to the coordinator, staff members say, "this is where it ends." Some staff have also claimed that shelter coordinators, if they disagreed with the information, have not forwarded the report or, if the original report was verbal, directed staff not to fill out an incident report. Once the shelter coordinator receives a report, it is sent to the supervisor. Some shelter coordinators reported that the supervisor has, on occasion, decided not to forward the information onto the licensing authority. The supervisor in question has denied this occurs. The OCA could find no documented evidence to support these allegations.

What was apparent in the OCA review, however, was that the agency's senior managers were not routinely copied on Incident Reports and were unaware of incidents in the shelters. During the OCA's review, the agency's process to review Incident Reports changed. Incident Reports are now forwarded to a committee of senior managers who then review them and can direct action. Agency managers say this committee process came into effect only when the agency was absorbed into the DFSH. When it became a branch of the DFSH, the agency was required to change insurance carriers. The formal review of incident reports is part of a process to document pre-existing conditions to satisfy insurance requirements[7].

Review of Incidents in the Shelters as Reported to the DFSH 2001-2003

Incident reports can be used to track child, staff or facility related issues and assist the WCFS and the DFSH to determine if patterns exist and to ensure that licensing requirements are met. Such tracking can be used to change or augment resources in the shelters to avoid incidents, to support staff or to address facility related issues that could contribute to incidents.

The DFSH is to be copied on every incident[8] and has a tracking system for all incident reports, but does not currently have the committed staff to regularly input the data. Without the composite information, analysis is impossible. The benefits are thus lost and the incident report becomes just another form required by government.

WCFS report that they do not have the ability to track incident reports and therefore do not analyze information contained in them. The benefits of tracking information and analyzing the data are lost.

The OCA focussed on the Incident Reports provided by WCFS to the DFSH. We reviewed all reports sent to the DFSH between 2001 and 2003. We wanted to determine what types of incidents were reported, where they occurred and the population of children and youth involved. Between 2001 and 2003, 33 shelters reported 957 incidents to the DFSH. We reviewed only those shelters that reported 24 incidents, or approximately one incident per month over the two years being studied.

Using these criteria the OCA reviewed 807 incidents reported by 14 shelters.

What the OCA Found

In the 14 shelters reviewed, 807 incidents were reported, meaning that our review covered 84 per cent of the incidents reported to the DFSH during the period. The number of incidents per shelter ranged from 24 to 115. On average, each shelter reported 58 incidents over the two years.

Six of the 14 shelters were three-bed units, one was a four-bed unit, four were two-bed units and three were designated as one-bed units. Total bed space available was 33 beds. Thirteen of the 14 housed both male and female residents; one was licensed for females only. Sexes were not mixed but the licensing allowed WCFS to place, in shelters housing 11 to 17 year old youth, either all males or all females. The shelters serving children ages 0 to 11 allowed for a mixed gender population. Eleven of the shelters reviewed were licensed for ages 11 to 17, one shelter allowed children ages 9 to 17 to be placed and two were licensed for children ages 0 to 11.

In 13 of the shelters, staff worked 12-hour shifts. One shelter allowed for 24-hour shifts. The OCA was unable to determine if the staff working in the shelters reviewed at the time of the reported incident were staff of WCFS or purchased-service staff employed by outside private contract agencies. The DFSH does not require the shelters to differentiate if staff are permanent, casual or purchased-service.

We noted a number of problems with the information in the incident reports provided by the DFSH. The quality of the information provided was lacking. The composite data from the DFSH data base was missing the last digit of the year, making it difficult to separate the reviewed years. In 2000 to 2001 only 17 incidents were reported. Therefore that year could not be included in our analysis. The reports themselves were not routinely filled out in detail and many lacked detailed and adequate descriptions of the incidents. This was important given that we had already noted problems in the definitions of incident types. A detailed description of the incident would have aided the OCA in determining incident type.

However despite these shortcomings we were able to discern patterns of incidents:

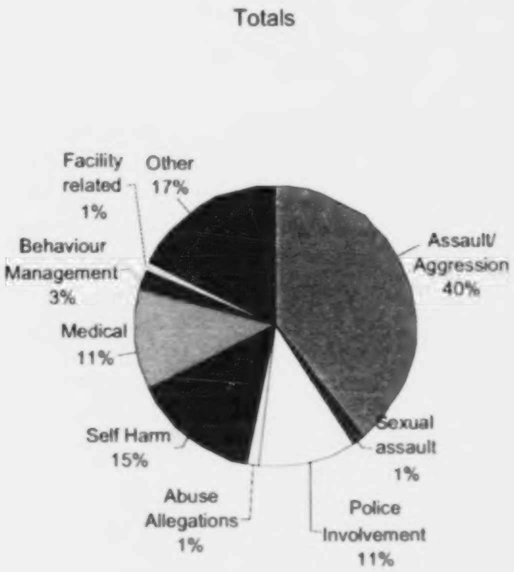
- 86 per cent (690) of the reported incidents occurred in shelters licensed for 11 to 17 year olds.
- 89 per cent (718) of the reported incidents occurred in shelters operated by shift staff working 12-hour shifts.

- 61 per cent (492) of the reported incidents occurred in four- and three-bed units. The one four-bed unit accounted for 105 of the reported incidents. All but two of the affected shelters housed 11 to 17 year old youth. The one three-bed unit housing 0 to 11 years old children accounted for only 33 of the 492 reported incidents.

The primary incident types recorded across all 14 shelters reviewed can be seen below in Figure 1.

Figure 1

Type of Incidents



The OCA also attempted to determine if there was a pattern to the timing of the incidents. The OCA reviewed five of the 14 shelters. The OCA concentrated on three-bed shelters housing males or females. As can be seen in the table below we found that the majority of incidents in shelters housing 11 to 17 year-old youth occurred between 6 p.m. and midnight (48 per cent). Twenty-three per cent of the incidents occurred between noon and 6 p.m. and 16 per cent occurred between 6 a.m. and noon. The majority of incidents reported were defined as "assaultive and aggressive behaviour" where the youth was identified to be the aggressor. All of the shelters reviewed had 12-hour staff configurations.

Table 1

Breakdown of Time of Incident Reported:

Time	Shelter A	Shelter B	Shelter C	Shelter D	Shelter E	Shelter F	Total
12 am – 6 am	4	2	19	0	6	8	39
6 am - 12 pm	19	3	29	4	9	10	74
12 pm - 6 pm	33	1	7	15	22	24	102
6 pm - 12 am	51	25	31	7	42	61	217
Unknown	8	0	0	2	6	4	20
Total	115	31	86	28	85	107	452

Clearly if this information was known to the WCFS and the DFSH, they could have taken steps to address the issues. For example, they could ensure an increased staff to child ratio between midnight and 6 a.m. or develop alternative day programming for youth not in outside day programming such as school or vocational training.

The three-bed shelter housing children ages 0 to 11 reported a level of assault/aggression of 70 per cent (the highest reported of all 14 shelters) and police involvement rose to 15 per cent of reported incidents. The majority of these incidents occurred between 6 a.m. and noon (40 per cent) and from 6 p.m. to 9 p.m. (30 per cent). This shelter was staffed using 12-hour shift configurations. Clearly, over a two-year period this shelter housing young children had a higher rate of reported assaultive and aggressive behaviour where a young child was identified as the aggressor. Staff also felt more often than staff at other shelters the need to involve the police - yet police involvement is not often the appropriate resource to deal with younger children.

What the Literature Says

The collection of systemically recorded incidents of aggression within child care settings can be used to predict and manage the individual child's aggression proactively. As found by Garrison et al (1990) when studying aggression and counter-aggression in a child mental health setting there are various combinations of child, staff and setting characteristics that can be used to predict incidents and thereby react proactively to them.[9] Garrison found that certain client and setting factors were associated with aggressive behaviour of clients and child management techniques employed by staff. He further suggested that the analysis of aggressive incidents and subsequent clinical management could be used to influence programming. Recurrent findings, related to such things as timing or location of the incident, would be helpful in program evaluations and planning for a safer and more therapeutic environment for children and youth.

The Provincial Child Abuse Investigator

In 1999 the DFSH created a Provincial Child Abuse Investigator (PAI). This individual is required to investigate allegations of child abuse made against staff, in all forms of residential child care facilities licensed by the Province of Manitoba, including youth correctional facilities.

The PAI does investigate allegations of abuse inside the WCFS shelter system. The role, however, is limited to investigating only staff employed by WCFS and not purchased-service staff. When allegations arise concerning purchased-service staff, WCFS social work staff investigates. Allegations against purchased-service staff are not considered a conflict of interest for WCFS and their own staff can, therefore, investigate.

The PAI role is to investigate abuse allegations and assess the veracity of those allegations. Abuse is defined under The Child and Family Services Act as

> An act or omission by any person where the act or omission results in:
>
> a) physical injury to a child,
>
> b) emotional disability of a permanent nature in the child or is likely to result in such a disability, or,
>
> c) sexual exploitation of a child with or without the child's consent.

The PAI role is limited to the definition of abuse and does not include investigating questionable or inappropriate child management practices. For an investigation to commence there must be a suspicion of abuse as defined under the *Act*.

The DFSH was asked to provide all reports completed by the PAI, as it related to the shelter system, up to March 2003. The DFSH complied. WCFS was asked to provide their responses to the PAI's report, if such responses existed. None was provided. Therefore, the OCA can only assume that WCFS did not formally respond to the PAI's report.

The Current Process

Either the DFSH Licensing Registrar or the WCFS forwards allegations of abuse by staff to the PAI. The PAI's investigation includes interviews with the victim(s) and the alleged offender(s). Agency files and shelter logs are reviewed as well as any other supporting documentation (i.e. medical reports). Once the investigation is completed, the PAI completes a report and sends a copy to the child's worker, WCFS abuse coordinator and the shelter coordinator. The report can substantiate or not substantiate the allegations, and in either case, can make recommendations. The PAI can also, based on a finding of abuse, refer the matter to the police for a follow up investigation, which could result in criminal charges.

Once the report is sent to WCFS, the PAI assumes that the recommendations are implemented. Her recommendations are not monitored for compliance by the DFSH. The PAI does not routinely submit her reports to anyone else in authority at the DFSH. If the matter is a potentially high-profile case, the report may be sent to their direct supervisor.

The PAI is also limited in the ability to make recommendations regarding an individual's employment status. The PAI can make a number of recommendations but cannot recommend disciplinary action, suspension or termination. These are matters that can be dealt with internally by WCFS through its Human Resource Department.

There appeared to be no formal process within WCFS to deal with the PAI reports. At one time the PAI's reports were sent to the Program Manager but the process was changed to direct the reports to the shelter coordinators. This change appeared not to be formally instituted but was a decision made to overcome a perceived delay in moving the reports back to the shelter coordinators. These reports were now sent to the coordinator at the shelter where the incident occurred and who supervised the affected staff. The shelter coordinator then shared the report with the shelter supervisor, or in the absence of a supervisor, the Project Manager.

As a result of this informal change, the reports were not routinely sent to the Program Manager, the Agency CEO, or the Director of Human Resources. In fact the Director of Human Resources when interviewed was only aware of one of the 28 reports reviewed by the OCA. Further, these reports are not routinely placed on the employee files even if there are concerns raised by the PAI as to the staff's interaction with the children. In the interview with the OCA, the PAI said she felt all of her investigative reports should be placed on the affected staff person's personnel file to assist in determining if there is a pattern of conduct. It is unclear from the interviews conducted by the OCA if these reports are consistently placed on personnel files. What is clear is that Human Resources are not routinely made aware of the reports unless a grievance is filed.

While this review was underway, a change in the process of dealing with the PAI report and other incident reports was introduced. The PAI reports are now also forwarded by the shelter coordinators to the Agency CEO, the Program Manager and the Director of Human Resources for information, direction and possible follow up. This new process is still not consistently understood by the shelter coordinators. When asked by the OCA who gets copies of the PAI report, only 54 per cent of the shelter coordinators said they send the report to the Agency CEO. Only 54 per cent stated they send a copy to the Program Manager and only 45 per cent indicated they send a copy to the Director of Human Resources.

The recommendations made in the PAI report are not consistently implemented and there is no process in place in WCFS to acknowledge the receipt of the report or respond formally to the investigator's recommendations. The implementation of the recommendations is primarily left to the individual shelter coordinator. What was reported to the OCA is that many of the recommendations made can affect employee status, as direction required might be construed as a disciplinary action, and/or there is a cost factor to many of the recommendations. The majority of the shelter coordinators interviewed stated that whenever possible the PAI recommendations are followed. However, if those recommendations have a cost factor or if the matter falls into the human resource area they have no authority to act.

What the OCA Found

During the reporting period requested (2000 to January 2003) the PAI completed 28 reports involving 37 children and youth and 28 staff.[10] Of the 37 children interviewed 25 were male and 12 were female. Investigations involved four (11 per cent) children ages 0 to 6; 10 (27 per cent) children ages 6 to 11; 14 (38 per cent) youth ages 12 to 15 and two (5 per cent) youth ages 16 and over. In five cases (19 per cent) the ages of the children were not identified. Overall, the OCA found the investigative reports to be of a superior quality, detailed in description where conclusions were reached and recommendations made. As well, it should be noted that the number of investigations and staff involved, constituted only a minority of staff working in the shelter system. The OCA, therefore, cautions that the reader should not assume that the PAI findings are reflective of the general practice of the majority of shelter staff.

The allegations resulting in the PAI report varied and as the reports are narrative interpretations of the allegations and can be subjective, they are difficult to place into defined categories.

However the majority of allegations investigated were incidents where children or youth alleged physical assault or aggression. The PAI found the majority of these allegations to be unsubstantiated.[11]

Though the PAI did not substantiate allegations of abuse as defined by the Act, a general theme of questionable child/youth management practices does emerge. The PAI reports consistently point to the use of physical force by staff to manage children and youth during conflict in the residence. Physical force is used to control or contain a child or youth; the intention is not to harm the child or youth. The reports do consistently comment on and question the use of physical force to contain, control or correct children and youth. As stated by the PAI in her interview with the OCA:

> **"They (staff) get too hands-on too quickly. They restrain too often and as soon as you go hands-on you can escalate the situation".**

The methods by which shelter staff used restraints are also concerning. The PAI said she felt a number of restraints used were inappropriate and could lead to injury of the child.

Though the PAI completed only 28 reports over the three years, 68 per cent of the shelter staff interviewed by the OCA admitted to physically restraining a child or youth during the term of their employment in the shelters. However, when asked to describe how they now manage a child or youth's aggressive behaviour staff qualified their answers to their current work situation.[12] The most common form of reported child behaviour management shelter staff reported using with children and youth, ages 0 to 12, was timeout or isolation (cited 38 per cent of the time); verbal redirection (cited 30 per cent of the time) and physical restraint (cited 14 per cent of the time). With youth ages 12 to 16+ staff reported using primarily verbal re-direction (cited 26 per cent of the time) or the removal of privileges (cited 26 per cent of the time); physical restraints (cited 17 per cent of the time), or calling for outside assistance (police/CSU - cited 20 per cent of the time).

The use of physical restraints is not uncommon in residential care and there are normally strict guidelines defining circumstances in which such actions can be taken. WCFS has instituted policies that outline the use of physical restraints. The policy is that the use of physical restraints is discouraged. Further, physical restraints are only to be used as a last resort and then only if the use of the restraint is needed to protect the child, other children or staff. Of concern to the OCA is that during the interviews of staff only 60 per cent of the staff were aware of the policies; 12 per cent indicated no such policies existed and 24 per cent were unaware of any policies guiding the use of restraints. Though coordinators and managers at all levels were aware of the policies, staff persons who directly care for the children were consistently unaware.

The PAI has pointed out these concerns as well as other questionable child management practices and has made a number of corrective recommendations. A primary recommendation is for additional training. In the PAI interview with the OCA, she cited the lack of training in dealing with behaviourally challenging children and youth as a common concern throughout the majority of her interaction with the shelter staff. The PAI has recommended additional training, including Nonviolent Crisis Intervention (NVCI). WCFS currently requires all shelter staff employed by WCFS to attend this training. The assumption is that the training will provide alternative techniques as opposed to the use of physical intervention and restraint. The PAI assumed that this training also provided information about the proper and safe methods of physical restraints.

But there is confusion about whether the NVCI training provided by the agency does indeed provide training in the proper use of restraints. As clarified by one WCFS manager to the OCA, the NVCI provides training in the use of restraints only for younger children. WCFS employ two staff person who provides training in NVCI. The training provided follows the Crisis Prevention Institute, Inc., *Nonviolent Crisis Intervention Training Program*. The current program offered by WCFS involves two days of training and emphasizes early intervention and nonphysical methods for preventing and managing disruptive behaviour. The program also trains in the proper use of restraints. Shelter workers are required to be certified in NVCI, but only once. The Crisis Prevention Institute recommends as does the WCFS trainer, that staff should be re-certified annually. This does not occur in WCFS because there are not sufficient funds to do so.

The WCFS staff trainer, like the PAI, expressed concerns about the shelter staff's possible inappropriate use of restraints. The shelter staff are trained to only restrain children or youth in precise ways. These methods avoid injury to a child. Generally, children and youth are not to be placed on the floor or held in a manner that obstructs airways or places pressure on the back or chest area. Shelter staff are trained to restrain youth in teams of two, using a holding technique involving only the arms and/or upper shoulders. It has been reported to the OCA that some shelter staff have used a basket hold with children as young as three, where the child has been placed on the floor[13]. Shelter staff report that they have been trained to use restraints in teams of two when dealing with adolescents. However, many times a staff person is alone with a youth and is unable to summon help. In one situation staff reported that they used a "leg sweep" motion to bring a youth down and then restrained on the floor. Clearly, inappropriate restraints can cause injury to a child or youth.

The Use of Physical Restraints

The use of physical restraints in the shelters with a highly vulnerable population of children and youth is concerning to the OCA. Physical restraint is defined by the OCA as "an intrusive procedure by which the child/youth/youth's motor activity may be reduced or prevented by physical contact with the staff's hand or body".[14] What the literature suggests is those children and youth that enter residential care and treatment facilities are highly vulnerable, with well-documented histories of maltreatment and deprivation (Garrison, et al, 1990 :243). These "children also suffer the psychological impact of the long term effects of abusive histories" (Bath, 1994) and thus may tend to "anticipate negative, punitive and rejecting responses from their adult caregiver and thus misinterpret cues wrongly attributing hostile intent"(Millstien & Cotton, 1990: 26)".

Troubled, and at times violent and aggressive, children and youth require our assistance. In provincial child care facilities and treatment centres, they can be restrained for their protection or the protection of others. The literature would suggest, however, that "there is a very narrow line between showing anger and aggression towards a child who is beyond control and seeking, for the child's own good, to control aberrant and destructive behaviours" (Lowenstien; 2003:17).

This line becomes even narrower in the shelter system. The restraint of children and youth in other child-care facilities is strictly regulated. The OCA reviewed the policies and procedures with respect to intrusive measures in three childcare residential treatment facilities.[15] All had detailed policies outlining the use of any intrusive measures and a mechanism in place for each facility to review their use. Comparatively, WCFS policies are limited. They state that physical restraints are to be used as a last resort but provide only general suggestions to avoid the use of restraints under certain circumstances. Limited training and use of untrained staff in the shelters create further complications as staff interaction with children and youth can further escalate a situation. This was a situation commonly found by the PAI.

The placement of children and youth with varying needs can further complicate the situation and the inappropriate matching of children and youth can create environments where acting out does occur. Eighty-four per cent of shelter staff interviewed believed the shelters were safe places for children and youth, however, 84 per cent also stated that residents do place one another at risk. All of the shelter coordinators felt residents place one another at risk. The primary peer-on-peer aggression reported by the shelter staff was physical threats and intimidation (84 per cent); verbal threats and intimidation (80 per cent) and physical assaults (76 per cent).

Literature would suggest that child behaviours which result in repeat seclusion or restraints include; "physical aggression towards staff, verbal aggression towards peers, non-compliance/oppositional behaviour", self harm and property destruction (Lowenstien2003: 50). Shelter staff and coordinators also suggested that peer-on-peer aggression can be influenced by the chronic histories and high needs of children and youth coming into the shelters and the resulting mix of high needs children. However, some staff and coordinators pointed out that lack of training and support for staff can also contribute to the inappropriate use of restraints. One shelter worker said that in his opinion often, "Kids don't place kids at risk, (untrained) staff do". This staff person's viewpoint is supported in the literature which suggests, "the most frequent precipitant of client assaultive behaviour is unfavourable interaction with a staff member" (Garrison, 1984; Soloff, 1981).

When conducting this review, our interviewers were often asked what they felt a staff person should do when facing a situation where a child or youth was out of control. The OCA in no way wishes to minimize the situations staff find themselves in. However, as found in other residential care settings, "interpersonal violence was largely predictable in terms of rather straightforward staff, patient and setting characteristics". Of primary importance to the shelter setting, is the environment of the facility and the programming offered. As cited in Triantafillou (1999):

> "A facility's programming variables may contribute to patterns of aggressive client behaviour. It has been found that programming times where the environmental and interpersonal stimulation is high, can lead to greater stress for patients (Millstien & Cotton, 1992). In particular, the frequency of restraints is related to "therapeutically demanding times" (Millstien & Cotton, 1992) for clients as well as transition times (shift change, scheduling of programming event) within the program (Garrison, 1984). This, in turn leads to an increased need for staff use of limit setting procedures, such a physical intervention, within the treatment program (Miller, 1986; Soloff and Turner, 1981; Gutheil, 1978; Wells, 1972; Redl and Wineman, 1952). In these situations, clients may be unclear of what is expected of them, who is in charge, and/or unclear of the sequence of event that may be follow. This point is particularly relevant to younger children who have greater difficulty making implicit connection to events and person that adult caregivers might take for granted (p. 5).

The OCA found that the physical environment of the shelter and the general lack of programming impacted on the quality of care provided.

What Children and Youth Say

"She is worse than my Mom," was how one female youth described her feeling about a staff person at the shelter.

Generally children and youth who were restrained felt angry, frightened and powerless. A number of children and youth entering the shelters have had well-documented histories of abuse and neglect. Many of these children often view the physical intervention by adults against them as a form of punishment for misbehaviour or non-compliance to adult authority. As a child and family service agency housing abused and neglected children, WCFS need to be cognizant of this very fact. As found by Bath (1994):

> "Abused or rejected children normally expect adults to be counter aggressive under these circumstances, since this is often congruent with their experience. Moreover, the heightened emotion will often arouse troubling memories from the past...."

There clearly has to be a better way.

The OCA acknowledges that WCFS discourages the use of restraints in the shelter system and that restraints are only to be used as a last resort and then only if a child is a risk to self or others. However, given the lack of training, the lack of detailed supportive policies and procedures, and the lack of an internal and external tracking system regarding the Provincial Investigator reports and incident reports, the use of physical restraints in the shelter system can lead to situations that place children and youth at risk.

The shelter system is a temporary emergency care system, not a system designed or staffed to provide long-term treatment services. Intrusive measures such as physical restraints can be appropriately used but in highly structured settings, with well-trained and qualified staff who are supported through onsite supervision with access to clinical supports. This is not the case inside the shelter system.

Youth Emergency Crisis Stabilization System (YECSS)

YECSS is a 24 hour community-based crisis intervention service for children and youth and their families who are experiencing acute psycho/social distress and behavioural difficulties. YECSS deals with issues ranging from parent/teen conflict to child/youth mental health issues. The overall goals of the program include the early identification of mental health issues, ensuring the provision of appropriate resources and referral to needed resources and preventing a child's community living situation from breaking down. There is a single point of entry for all services. Community members, including CFS agencies, foster parents, group homes and shelters requiring services can contact a single intake number. If appropriate a Mobile Crisis Team (MCT) can be dispatched. If the MCT believes it is required, a child or youth can be placed in a Crisis Stabilization Unit (CSU) for up to 72 hours. Clinical follow-up can be arranged following discharge from the CSU.

The first formal policy that directed shelter staff to access the YECSS program was the 1999 Protocol for Accessing Assistance in Dealing with Children who are Out of Control. This protocol directed shelter staff to call MCT if children under the age of 12 were out of control, but not "assaultive", for assistance.[16] The 2001 Behaviour Response Manual (part of EAPD Home

Manual) also directed shelter staff to contact the MCT if staff are unable to calm a physically acting out child or youth.[17]

When the OCA asked shelter staff how they managed violent or aggressive behaviours of children or youth, eight to 12 per cent of the staff reported calling the YECSS, known inside the system as CSU. Specifically, eight per cent of staff report they would call when dealing with aggressive or violent children ages six to 12; 12 per cent reported calling when dealing with violent or aggressive children ages 12 to 15 and eight per cent would call when dealing with youth ages 16 +.

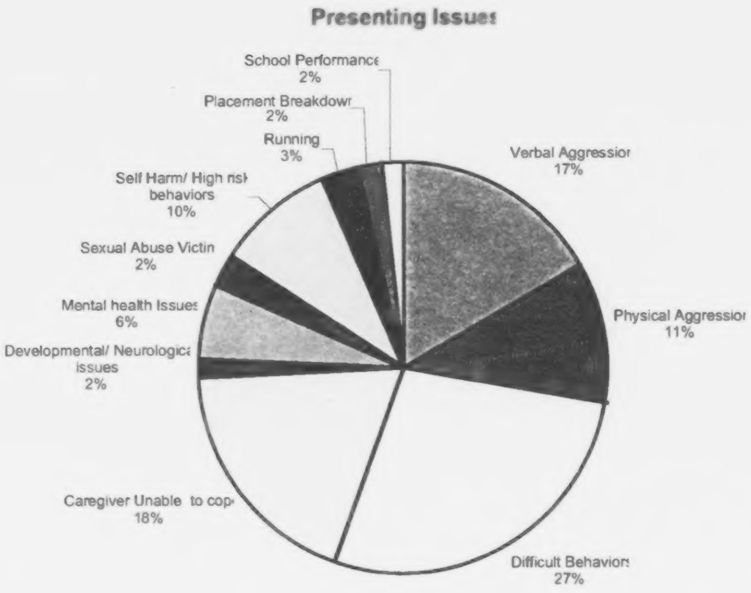
The OCA wanted to explore the frequency of such contacts and their outcome. The OCA interviewed a YECSS executive manager and requested summary data of YECSS contact with children and youth at the shelters. Information was provided to the OCA about the program's activity with the shelters from April 2002 to May 2003.

During the reporting period YECSS recorded 5,662 total contacts with the community requesting assistance, the majority of which were initiated by a parent. The EAPD program accounted for only 107 or 1.8 per cent of the total. Comparatively, residential care (residential group care, treatment centers and street shelters in the community) accounted for 411 or 7.2 per cent. Requests for YECSS services from foster parents accounted for 195 or 3.4 per cent. Total CFS requests for service of YECSS calls account for 944 or 17.5 per cent of the total.[18]

At the time the EAPD shelters housed 975 children and youth. One hundred and seven requests cannot, in the OCA's opinion, be considered an excessive number of contacts. The ratio of YECSS contact calls to placed child suggests that there was one YECSS contact for every 9.1 children or youth placed in the EAPD shelters for the reporting period. It also appears that the frequency was not excessive when one compares the YECSS contact with other group care.[19] YECSS reported that group care initiated 411 requests for services in the year 2002 to 2003. In 2002 and 2003 there were approximately 272 group care beds available and as reported by the DFSH 333 children and youth were housed in group care across Manitoba.[20] Group care requested service from the YECSS program 1.2 times for every child placed in group-care across Manitoba. Clearly the frequency of YECSS contact by other group care is higher than the frequency of contact in the shelter system.

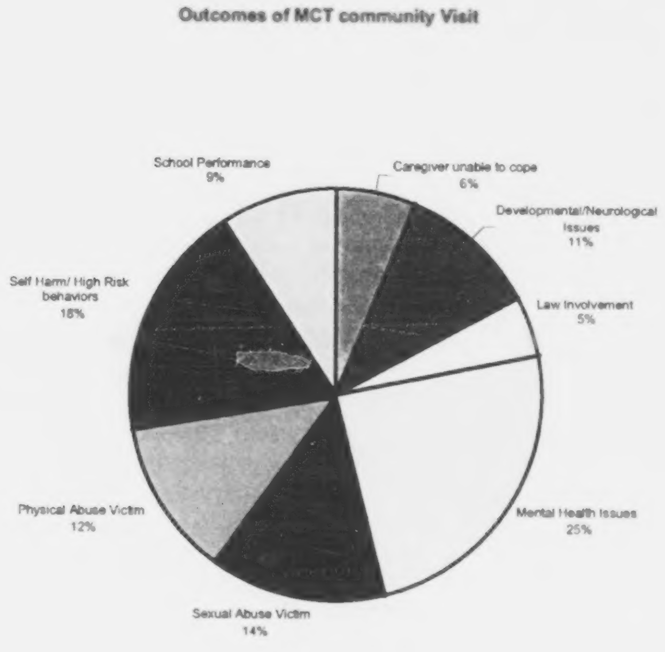
Though the frequency of the shelter contact with the YECSS program was not of concern, the OCA found the reason for contact and the assessed outcome more telling. YECSS provided the OCA with the reasons or major issues recorded at contact.[21] As can be seen in Figure 2 the highest recorded issues resulting in the request for service was identified as a child or youth exhibiting "difficult behaviour" (27 per cent); caregiver unable to cope (18 per cent); verbal aggression of child/youth (17 per cent) and physical aggression of child/youth (11 per cent).

Figure 2



The MCT was dispatched to the shelters 65 times out of the 107 contacts or requests for services. The team assessed and categorized the primary or presenting issues they found. As can be seen in Figure 3 following contact the MCT assessed presenting issues as mental health issues of child or youth (25 per cent); caregiver unable to cope (18 per cent); sexual abuse victim-child/ youth (14 per cent); physical abuse victim–child/youth (12 per cent) and developmental neurological issues of child/youth (11 per cent).

Figure 3



Caregiver or the staff inability to cope is consistently recorded at 18 per cent of initial requests for service and the assessed presenting issue once the MCT arrives at the shelter. YECSS indicated that 49 per cent of the children and youth were settled at the shelter but 31 per cent were removed to the CSU.

When questioned about what was typically found in these cases, YECSS stated that in a number of entries they found a lot of "struggle locks" between staff and children/youth. "Struggle lock" means that staff involved in the YECSS contact were locked into a "disciplinary role" that may have contributed to the escalation of the situation. When such power struggles are assessed, the MCT attempts to provide support and suggestions to shelter staff about how best to handle situations to prevent further escalation. YECSS staff added that when the MCT enters a shelter and finds only purchased-service staff on duty the MCT would automatically remove the child or youth to the CSU.

The YECSS team reports any concerns (i.e. use of restraints, inappropriate staff conduct, facility related issues) affecting the care of children or youth in the shelters by filing an incident report and forwarding it to the DFSH, specifically to the Coordinator of the Provincial Placement Desk-Managed Care Team.

Shelter staff reported to the OCA that they believe the YECSS program does not consistently respond to their requests for YECSS services. It would appear that EAPD has held this opinion since 1998. In 1998 the EAPD program felt there was an insufficient emergency response system in place to help EAPD workers dealing with volatile situations. There were complaints that lack of YECSS response was leaving shelter staff feeling isolated and unsupported. This situation was exacerbated when purchased-service staff were used, as they were often unable to deal with children and youth that were in crisis.[22]

A committee of EAPD coordinators in 1998 recommended that the agency create an internal Emergency Response Team that would liaise with YECSS and other emergency response systems (such as police and health.) The team would react to crisis inside the EAPD system (shelter, hotels and foster homes) involving staff and children. The team would also act in a "proactive manner" by providing support and after-hours supervision to the EAPD system. Finally the committee recommended the creation of two Emergency Care Units (ECU) of four beds, one unit for males and one for females. The houses would serve children and youth ages seven to 17 and would be staffed by highly-skilled personnel working eight-hour shifts. The ECU would take aggressive children and youth for short periods of stabilization. The staff would act as liaisons with other services to quickly stabilize and move the children or youth to long-term care facilities. This proposal was never implemented, leaving the EAPD system reliant on outside services or on the agency's night-duty system.

Overall, however, the OCA found that the shelter system was not excessively using the YECSS system to deal with acting-out or aggressive children and youth. Compared to other residential child-care facilities, they seem to be in fact under-using the program. Their under-use of the program, coupled with the stated opinion that YECSS does not adequately respond, should be further explored by the DFSH to ensure response and service levels are adequate.

Winnipeg Police Service (WPS)

Agency policy enables shelter staff to involve the WPS when in need of assistance:

- To contain or control an acting-out child or youth and there is threat of physical violence and or use of weapons (*Restraint Policy November 1, 1999; Physical Acting Out, February 28, 2001; Not Settling at Bedtime, February 28, 2001*), and/or
- When there is threat of or damage to shelter property (*Damaging Property in the Home, February 28, 2001*), and/or
- When the child or youth is missing or has run away (*AWOL's February 28, 2001*), and/or
- When the child is under the influence of drugs or alcohol and at risk (*Drug and Alcohol Usage, February 28, 2001*), and/or
- When there are incidents of theft or suspected theft that require the physical search of children (*Theft, February 28, 2001*), and/or
- When the child or youth has been a victim of sexual assault or sexual exploitation (*Sexual Abuse; Sexual Activity-Prostitution, February 28, 2001*).

Police can also attend the shelters if they receive a complaint from the community that they believe merits their involvement. Each request for police assistance or police contact initiated from a community complaint must be documented in an incident report filed with the shelter coordinator. However, agency policy does not clearly outline if and when staff should record incidents of police contact in either the child's log or staff log.

The OCA noted that in the 957 incident reports filed by the agency with the DFSH (2001-2003), police were involved in 11 per cent of the incidents. Given that it was reported to the OCA that incident reports were not consistently filled out (see Incident Report section) the OCA wanted to further explore the involvement of police in the shelters. The OCA asked WPS how many times police were called to the shelters to respond to "acting out children or youth" for the fiscal year 2002 to 2003.

WPS reported attending 26 shift staff shelters 155 times in the fiscal year 2002-2003 (police also reported 10 calls to two professional parent homes in the EAPD program; these calls were removed from the OCA analysis). During this time WCFS operated 51 shift staff shelters. This equates to police attending a shelter every 2.35 days over the year reported. These 155 contacts were not necessarily in response to one child or youth but could involve multiple children or youth. In reviewing the information, however, the OCA suspects that in 17.5 per cent of the calls or 29 calls police were likely responding to a single child or youth that staff had consistently requested assistance in dealing with.

The WPS information did not consistently report age or gender of children and youth involved in the call. The OCA also attempted to cross-reference the calls by address of shelter and then by license issued to determine age and gender of child placed. The OAC could not consistently determine gender and only to a certain extent could we accurately determine age of child or youth housed in the shelters. This is because populations in the shelters can change and a shelter can at separate times care for children across the age range of 0 to 17 and gender, dependent on the agency's need for placement. The OCA was able to break down shelters by shift configuration and age range as of May 2003. As can be seen in Table 2, 97.5 per cent of the WPS contacts occurred in shelters with a shift configuration of 12 hours. Almost eighty-nine per cent of these calls were responding to youth ages 11 to 17. The OCA cautions that 12-hour configurations were used in the majority (80 per cent or 41 shelters) of the shelters during this time. As well 12-hour shift configuration shelters primarily house youth ages 11 to 17. Therefore it is not unexpected that these shelters would have more police contact.

Table 2

12 Hour shifts (24 Shelters)		
Age Range of Children (license)	**# of Calls**	**% of Calls**
0>11	9	6.0
11>17	134	88.7
9>17	7	4.6
0>17	1	0.7
Total	151	100
24 hour shift configuration		
0>11	4	2.6
Total	**155**	**100**

The OCA then reviewed the "reason for attending" as provided by WPS. WPS did note multiple reasons per call. The reasons as provided were descriptive and narrative (i.e. Two youth fighting; resident assaulted resident; 14 year old female attempted suicide). The OCA then categorized these descriptors into child specific; peer-on-peer violence; violence directed towards staff; use of weapons; theft; property damage and other. Though the OCA requested only contacts for "out of control child or youth," as Figure 4 demonstrates there were varying facets to being considered out of control.

Figure 4

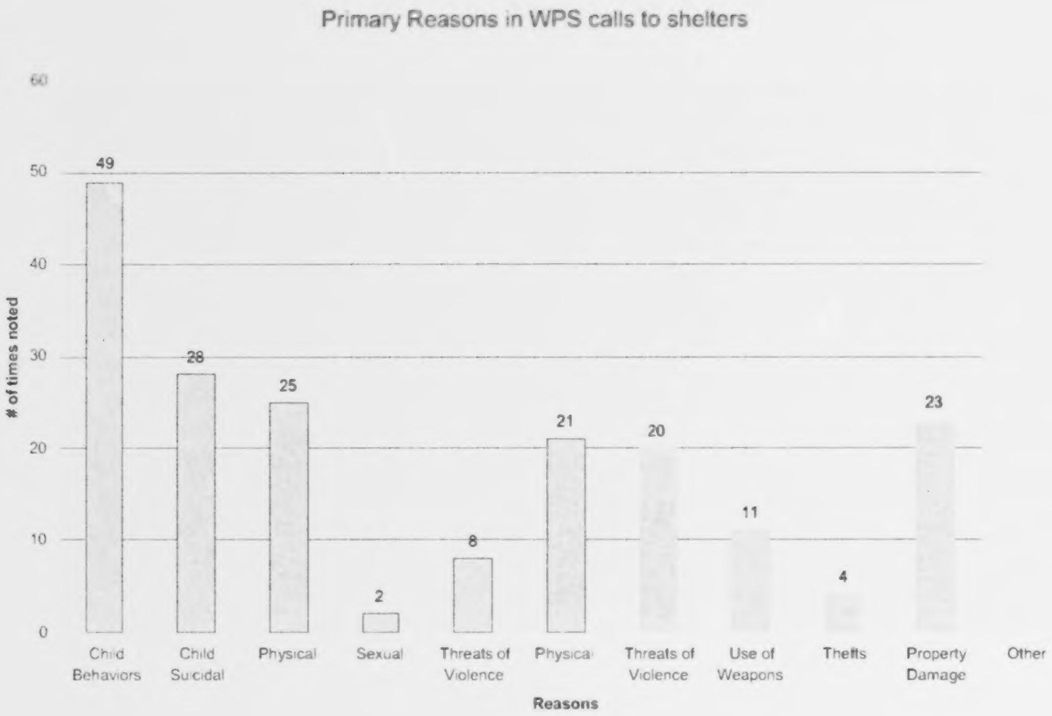

Primary Reasons in WPS calls to shelters
# of times noted
60
50
40
30
20
10
0
49
28
25
2
8
21
20
11
4
23
Child Behaviors
Child Suicidal
Physical
Sexual
Threats of Violence
Physical
Threats of Violence
Use of Weapons
Thefts
Property Damage
Other
Reasons

Figure 4

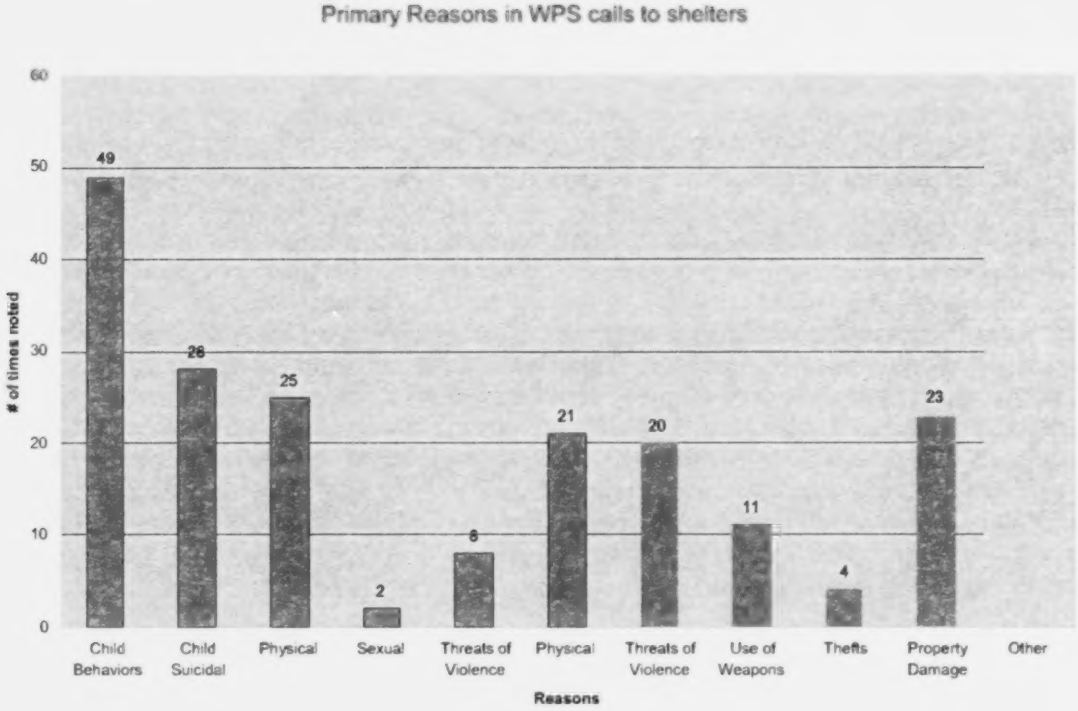

Primary Reasons in WPS calls to shelters
60
50
40
30
20
10
0
# of times noted
49
28
25
2
8
21
20
11
4
23
Child Behaviors
Child Suicidal
Physical
Sexual
Threats of Violence
Physical
Threats of Violence
Use of Weapons
Thefts
Property Damage
Other
Reasons

Table 3

Primary Reasons in WPS calls to Shelters		
Concern	**Number of Times Noted**	**% of Time**
Child Behaviours	49	7%
Child Suicidal	28	14%
Peer on Peer Violence		
Physical	25	13%
Sexual	2	1%
Threats of Violence	8	4%
Violence Directed to Staff		
Physical	21	11%
Threats of Violence	20	10%
Use of Weapons	11	6%
Thefts	4	2%
Property Damage	23	12%
Other	7	4%
Total	198	100%

The primary reason for WPS contact as can be seen in Table 3 was child specific, 39 per cent; violence directed towards staff, 21 per cent and peer-on-peer violence, 18 per cent. Of concern to the OCA is that in the child specific category 14 per cent of contact with WPS was related to attempted suicide. The OCA cannot determine if these calls were followed up with contact with child mental health officials. However, the OCA did note that the shelter system appears to be under-using the YECSS system and shelter workers report that the YECSS system is non-responsive to their needs. The OCA cannot determine if their opinion is accurate. Certainly calling 911 in an emergency situation is appropriate. But often contact with the YECSS system is equally appropriate as they are designed to react in crisis situations.

The OCA cannot determine if the staff involved were agency staff or purchased-service staff. We cannot match incident reports to police information but as found by the OCA, 957 incident reports were filed by the shelter system to the DFSH between 2001-2003. Eleven (11 per cent) were related to police involvement. This means approximately 105 incidents were filed concerning police involvement over two years. WPS noted in only one year (2002-2003) 155 contacts. Clearly WCFS are not complying with licensing requirements regarding reports of police contact.

The WPS information reveals that shelter staff have involved the police every 2.35 days primarily responding to youth. Youth appear to be engaged in high-risk behaviours resulting in staff believing they require police assistance. The OCA cannot assess if the staff correctly identified the need for police assistance. Using police to quell a situation can, however, be described as an intrusive form of intervention used in extreme situations. Requests for police assistance every 2.35 days is too common, leading the OCA to ask: Are youth acting out in their environment or reacting to their environment? Others have commented to the OCA that shelter staff, likely due to a lack of formalized training, contribute to situations that can escalate beyond their control.

Simply a Matter of Training?

Other shelter workers and shelter coordinators also reported that shelter staff sometimes get into power struggles with children, which can result in an escalation of violent or aggressive behaviour and the use of intrusive measures to control them. When asked if they had witnessed or been advised of situations where shelter staff engage children or youth in a manner that causes the escalation of violent or aggressive behaviours:

- 68 per cent of shelter staff reported witnessing such incidents;
- 63 per cent of the shelter coordinators reported that they were aware of such incidents.

The DFSH Provincial Abuse Investigator also reported that in her opinion staff "get too hands-on too quickly" and generally have had difficulty dealing with behaviourally challenging children or youth. Generally all interviewed by the OCA cited need for training to help deal with such children and youth.

Training certainly is of assistance in dealing with challenging behaviours of children and youth. However a number of other themes emerged during the OCA review that contributed to, and impacted upon, shelter staff's ability to manage child and youth behaviours. These included:

Physical layout and location of the shelter. (See Part 4)

The Matching of Children and Youth in the Shelters

The majority of shelter staff, coordinators and program managers stated that shelters cannot turn away children or youth and as a result children and youth with varying needs are placed together. Inappropriate matching can cause high-stress situations where children and youth react aggressively to one another and to staff. Shelter staff complained that when they request a child or youth be removed for safety reasons or that additional staff be added, shelter coordinators and agency managers question the staff person's ability and skill. WCFS stated that they indeed are concerned about staff and child safety, but point out that often a lack of staff skill coupled with the agency's inability to match child to shelters due to a chronic resource shortage, contributed to situations that escalate beyond staff control.

The Matching of Child Presenting Needs to Staff Skill

As the EAPD program developed a general assumption appeared to take hold that child-care workers should be able to care for all children. The EAPD program cares for children and youth ages 0 to 17 with varying and often extreme needs. The resources crisis in the agency certainly has not afforded the agency the opportunity to place their most skilled shelter staff with their most needy children. However, not all staff should be expected to be able to work with all types of children coming into care and their corresponding needs. It also was reported by shelter staff and coordinators, and confirmed by the review of the Provincial Abuse Investigator's reports, that some staff experienced problems in managing certain age groups of children or youth. Some were moved to other shelter sites, housing different age groups, without always receiving additional training. A staff person who had difficulties caring for younger children may now be transferred to work in a shelter that house adolescents. This practice leaves the OCA to question what is accomplished by moving a staff member who has already used inappropriate child management techniques.

The agency has never completed a review of its present staff and their level of skills and expertise.[23] Certainly there are skills common to all levels of the child-care profession. However, additional and specialized skills are often required to work with sub-populations of children, such as the younger child, the physically challenged child, the child with pervasive developmental delays, the victimized child or the child who is diagnosed as suffering from Fetal Alcohol Syndrome. Shelter staff are not consistently provided with training in these specialized areas. Children and youth with these and other challenging issues are placed inside the shelters. The agency does not expect that each child will have similar needs but the structure of the EAPD program assumes that all shelter staff as childcare workers possess an equivalent set of skills to deal with all children and youth. This is simply is not possible.

The Shift Configurations

The current guaranteed 12 and 24-hour shifts also have an impact on care. Shelter staff report that the 12- and 24-hour shifts are lengthy, and given the needs of the children and youth in the shelters, can cause fatigue. When staff members are tired, mistakes in judgment can be made. However, union officials argue that 12- and 24-hour shift configurations allow for a consistency of care, particularly for the acting out adolescent or for younger children who require a constant face from which to seek reassurance. They believe that shorter shift homes should be used for children and youth who do not require or may not be able to handle a constant presence of staff.

However, as one can see in the Incident Reports, the OCA found that over a two year period 89 per cent of the reported incidents occurred in shelters with 12-hour shift configurations. Further, the vast majority of incident reports involved shelters housing youth ages 11 to 17. Incidents in these shelters occurred primarily between 6 p.m. and midnight. Clearly, caring for often high-needs pre-adolescents and adolescents is stressful. Lengthy shifts can contribute to this stress.

The guaranteed shifts and accompanying hours also impacts on the agency's ability to move skilled staff to needed areas. Though staff are not guaranteed their work site, the agency reports that the guaranteed shift configurations in essence can prevent the movement of staff to needed areas. As the agency moves towards consolidation, the guaranteed shift configurations and hours hamper the movement of staff. Staff are moved to sites where their shift configuration and hours can be met as opposed to moving staff to meet the needs of the child. Some staff may now be working with children or youth not because they have the particular pre-requisite skills, personality or patience to work with them, but because the agency is required to guarantee a particular shift configuration and number of hours.

The Use of Purchased-Service Staff

When the agency cannot fill a shift with a permanent employee or a staff member who works on a regular casual basis, they employ purchased-service staff. Shelter staff reported problems when purchased-service staff are used. When asked if shelter staff paired with purchased-service staff work well as a team, 56 percent of shelter staff responded they did not. The shelter coordinators do not supervise purchased-service staff and appear to know little of the impact mixing permanent and purchased-service staff has on care. When asked if shelter staff and purchased-service staff worked well as a team, 27 percent of coordinators thought they did, 18 per cent thought they did not but 54 percent of coordinators could not provide a definitive answer to this question. It would appear that purchased-services staff are supervised primarily by their *employing agency.* For at least one contract organization this appears to include some on site supervision. One purchased-service supervisor told the OCA that he goes to the shelters and the hotels to check on his staff. He added that he is called if there is trouble, before a call goes to WCFS. He described how on one occasion he entered a hotel and spoke with a troubled youth as a result of a call for assistance by one of his staff.

This intervention in the opinion of the OCA, is unacceptable. Many children and youth that enter the shelters do so at a time of crisis. Their interaction with trained and skilled staff can be difficult. Unnecessary interaction with individuals, possibly even unknown interaction to the guardian agency, causes us concern and is at the very least a breach of the child's right to confidentiality.

The OCA cannot comment on the skill of the purchased-service staff as only two individuals who are employed with purchased-service agencies chose to be interviewed. In the OCA interviews conducted with children and youth they cannot tell which staff are WCFS staff and which are purchased-service staff. This causes concern to the OCA, as it also appears that children and youth in the shelters were generally unaware of their rights and were unaware of who they could go to if there were problems in the shelter.

Education

Children and youth enter into care of the child and family service system when they are in need of protection from abuse or neglect, and when a family crisis leads to an out-of-home placement. For many of these children, emergency temporary care and stabilization is the priority at the outset of agency involvement. Often out-of-home care requires a child or youth to reside in a setting some distance from their home. And, in the pursuit of family reunification, and the resolution of protection concerns or family crisis, educational continuity is not considered of primary importance in planning for children residing in emergency out-of-home care.

Whether children enter into the EAPD shelter system from family home or alternate care resource, disruptions to education are inevitable. Relocation to another area of the city, the nature of shelter care and ongoing case planning all present barriers to the child/youth's continued school attendance. These barriers are magnified for children within the shelter system.

Relocation

Relocation can mean that a child or youth must move to a new school near the shelter, thereby affecting educational stability. Research demonstrates that "changing schools disrupts the educational progress and hinders a child's ability to learn and succeed academically. It is estimated that when children change schools, they lose an average of four to six months of educational progress. School records may be lost or their transmission may be delayed leading to a lack of continuity and possibly difficulty in receiving needed services for special needs students".[24]

Children face many obstacles when changing schools. Peer groups, academic performance, extra-curricular involvement, and in some cases academic support and assistance are affected. Children with disabilities in the shelter system often experience long absences from school while awaiting co-ordination of necessary resources and transfers of funding for specialized programs. For many of these children school "can provide a child with source of continuity in a relatively stable and potentially supportive community in a guaranteed and predictable environment, particularly when the family unit or foster placement breaks down."[25]

Relocation does not always result in change of schools. In some cases, children and youth within the EAPD shelter system have been able to maintain their initial school placement as the shelter may be within the same school boundaries as the previous placement. As previously reported, in situations where children are placed outside of the geographical boundary of the school, transportation arrangements are made to facilitate continued school attendance. For adolescents, this takes the form of public transportation such as transit buses or taxicabs whereas agency support workers, or shelter workers drive younger children. Unfortunately, transportation by agency personnel is not always accessible, or financially feasible. If agency representatives are transporting multiple children to an array of schools, a child's school schedule is altered to accommodate the driving schedule of the agency workers. Accessibility and co-ordination of transportation inadvertently contributes to sporadic and disrupted school attendance.

The Nature of Shelter Care and its Impact on Education

Because shelters are staffed in shifts, children can potentially have several caregivers. The absence of primary caregivers often presents difficulty in communication between the school and the children's home environment. School personnel have reported to the OCA that children in shelter care are educationally impacted by the lack of a primary caregiver. Attention to the completion of homework is not always the focus of staff caring for several children of varying age and need. Further, communication books between the school and the home are not consistently used as the commitment to this method of communicating appears to be dependent upon whether the employees are regular staff or casual staff. Finally, children residing in shelter care with several caregivers are not always represented at parent teacher conferences. The shelter often defers to the worker and the worker views the shelter as caregiver, to have primary responsibility in meeting with teachers.[26] "Open communication among the social workers, teachers and care providers is essential if the children's educational needs are to be served."[27]

Case Planning in Relation to a Child's Educational Needs

For social workers in child protection, the emphasis in case planning is on resolving protection concerns and where possible, family re-unification. Once a child enters temporary care, efforts are made to preserve family contacts through visitation. For most children, family visits occur within agency offices during school hours, requiring the child's absence from school. Disruption to school attendance is heightened for children whose families are involved in the re-unification process, where visits are more frequent.

Case planning takes a higher priority than a child's educational needs. Children in temporary care are often unable to participate in school related functions, or after school extracurricular activities because of conflicts with family visitation, or other case plan issues such as therapy. Although protection elements of case planning are paramount, the education of a child is also of significant importance, particularly in the long-term. "Education will affect the quality of life in adulthood...more emphasis must be focused on the educational needs of foster children by all professionals involved."[28]

PART 7: FISCAL AND HUMAN RESOURCES

The Costs of Care and Analysis

The OCA asked WCFS for a breakdown of the costs of shelter care from 1998 to 2003. The breakdown was to include the average per diem cost per shelter and a line by line breakdown of that per diem cost. The OCA received total costs for the five years requested and a breakdown of the cost for the fiscal years 2000 to 2003.[1]

TABLE 1

Costs of Care
Shelter Cost 1998 - 2003

Year	Estimated No. of Shelters[1]	Average No. of Children[2]	Days in Care	Total Cost[3]	Average per diem	Total per day cost
1998 1999		103	37,712	6,938,300	$189.98	$17,502
1999 2000		109	39,785	8,154,087	$204.95	$22,340
2000 2001	72	107	39,050	8,760,240	$224.34	$24,004
2001 2002	67	127	46,542	11,377,908	$244.46	$31,046
2002 2003	51	123	44,990	10,778,641	$239.57	$29,530
Total		**569**	**208,079**	**$46,009,176**	**$220.30**	

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[1] The OCA could not obtain accurate information as to the exact number of shelters between 1998 – 2000. We know the agency reported 16 to 34 shelters during this period of time.

[2] Average number of children housed per day in the shelter system over 365 days.

[3] Total cost includes only salaries/benefits of shelter workers and purchased services, building maintenance. In 2000-03 care cost associated with closing and opening shelters, other, EAPD dispatches and drivers are included.

The Increased Costs of Shelter Care

It appeared that the overall cost of the shelter system steadily increased regardless of the number of shelters. This increased cost, according to one senior manager contributed to the overall agency deficit. Agency managers attributed the overall increase to two primary factors beyond the agency control.

The Needs of Children and Youth

Agency staff said the need for the shelter system grew because more children were coming into care, the corresponding complexity of presenting needs and the lack of alternative placement resources. When unable to place a child in alternative care, the agency would use the shelters. Some children placed in the shelters were children whose high needs stopped the agency from placing them with other similar or same age peers. These children were placed in one- or two-bed shelters. This had an impact on the overall bed availability for the agency but did not necessarily mean a corresponding decrease in the cost of running a shelter. Given these children had high needs and alternative care resources were not available, some spent longer periods of time in shelter care.

Three examples were evident in the breakdown of shelter cost for the fiscal year 2002 to 2003. The average per diem cost reported by WCFS was $237.79. In that year the agency separately placed three high-needs youth in three single-bed shelters. At times, the needs of children and youth would dictate the agency double or triple staff a shelter. These single-bed shelters reported per diem costs of $454.48, $443.05 and $471.55 respectively. The total salary cost to the agency for these children was $423,601.00 or five per cent of the total staffing costs associated with shelter workers in that year.

Given the number of licensed beds in the shelters, the total days in care available to the shelter system were 50,370. The agency recorded using 44,990 days. This meant that the agency used 89 per cent of the total days that could be accommodated by the shelter system. The number of available beds was reduced by the need to create one- and two-bed shelters for high needs children and youth. However, the costs associated with the maintenance of shelter system (administrative support costs, capital costs, facility-related costs, etc) remain constant.

The Costs of Staffing

The agency also cited high staffing costs. WCFS managers reported that the 24-hour and 12-hour shifts and the guaranteed shift configurations contributed to the increased cost.

In a May 21, 2002 Issue Note the agency reported that "while the hourly rate in the agreement is consistent with industry standard, the fact that staff are guaranteed 24-hour and 12-hour shift results in an extraordinarily high annual salary".[2] The agency further reported that this increase in salary above the industry hourly rate appeared also connected to the overtime payment for these staff.

Managers also said guaranteed shift and shift configurations made it impossible sometimes to move staff to where they were needed, meaning purchased-service staff had to be employed to fill the gap.[3] Shelter coordinators have explained that though employees are guaranteed shifts, they are not guaranteed work site location. But it was sometimes impossible to reconcile the guaranteed shifts with the shifts required at specific shelters. The agency reported often having to deal with these situations by employing casual or purchased services.

The OCA has looked at the cost of salaries and benefits as a percentage of the total direct shelter cost over three years 2000 to 2003. As can be seen in Table 2 the staff costs range from approximately 72 to 80 per cent of the shelter costs.

Table 2

Costs of Care
Salary and Benefits

Year	Staff Cost	Total Cost	Percentage of Staff Cost of Total Cost
2000 2001	6,374,270	8,764,069	72.7%
2001 2002	8,994,624	11,377,905	79.1%
2002 2003	8,664,957	10,778,641	80.4%

Across residential care facilities, specifically group homes that house six children or youth, a staffing cost of 72 to 80 per cent of care cost is not outside the industry standard.

The Allocation of Funds Inside the Shelters

Shelter staff, union officials, coordinators and managers told the OCA that shelters were not adequately funded. During OCA interviews a minority of staff raised allegations of theft and or missing items (primarily food).

To run the individual shelter the agency must disburse monies to purchase food, household supplies and to fund incidental items such as children's allowances. The agency is also required to provide meals to shelter staff. It is unclear how money was disbursed to individual shelters before appointment of the Project Manager. Some coordinators and staff stated money was given to a key or senior shelter worker who would then be responsible for purchasing food and household items. There were complaints of a lack of accountability.

The Project Manager quickly noted the problems and instituted a system that would enhance accountability. The Project Manager also noted funding to the shelters was not in line with funding to other residential care facilities and attempted to set up a chart of accounts using a residential care model.

The new system required one to two permanent shelter workers in each individual shelter to open a personal bank account and obtain a PIN number and cards. The agency paid all bank charges associated with these accounts. Each shelter was provided funds based on the bed space as can be seen in Table 3.

Table 3

Costs of Care
Shelter Allotment Base on Bed Space

Daily rates	1 or 2 bed	3 or 4 bed	> 4 bed	*Shelters
Food	18.08	25.53	33.11	Directly Billed
Household allowance	4.27	4.27	4.27	4.27
Recreation	5.75	6.41	6.41	6.41
TOTAL COST	**28.11**	**37.22**	**43.80**	**43.80**

Semi - Monthly Allotment	427.50	556.05	666.05	152.50
Monthly Allotment	855.00	1,132.10	1,332.10	305.00

Each shelter is provided funds on a semi-monthly basis no matter if the allotted beds are filled. The reasoning for providing funds based on bed numbers as opposed to beds filled is that the shelters need to be operational and ready to accommodate a full complement of children and youth. The shelter workers deposit the money in the bank account and draw from that account. All receipts are forwarded to the shelter coordinator who then reconciles the receipts and forwards to an accounting clerk who again reconciles the receipts.

This system allows for surpluses to be built for the purchase of household items, such as VCRs or other equipment needed. The agency has no inventory control system to itemize these purchases and catalogue the whereabouts of purchased goods. The OCA recommended to the Project Manager that an inventory control and catalogue system be implemented.

Extraordinary purchases outside the allotments require justification and approval of the shelter coordinator and are authorized by the shelter supervisor and Project Manager. These funds are provided through a direct disbursement.

As stated, the OCA heard allegations that theft was occurring and or items (primarily food) would go missing. When these concerns were raised to the managers in the agency and to the DFSH we heard one of two things: "You can't prove it so how can you ever address it" or, as managers they were unaware of the allegations. One WCFS manager said it was her opinion that the allocation system was "a smooth running system."

The OCA acknowledges that it was impossible to prove individual allegations as many were based on rumour and hearsay. As well, the OCA acknowledges that the amount of money available to the individual shelters is limited. However, we became concerned when we asked questions about what checks and balances were in place. For example, there was no inventory control system. Shelter staff reported food shortages, and using their own personal money to buy food for children and youth. The OCA had attended a shelter housing young children, where there was a complaint of food shortages. The shelter staff member who was to buy the food was off shift and no one had access to the PIN number. We attended and confirmed the food shortage, reported to the agency and they immediately responded.

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* At the time of this review, four shelters with bed spaces ranging from one to two beds directly bill the food allotments with a local distributor.

The Children's Advocate, however, reported concerns to senior officials in the DFSH. They too were concerned. It was agreed that the Internal Audit and Consulting Services (IA) would be asked to assist in ensuring the "financial practices and procedures within WCFS shelter system" were "consistent with the generally accepted accounting practices".

As well, though the agency made a concerted effort to reduce the number of shelter beds, the costs of EAPD placements (hotel, shelters and interim foster homes) over five years consistently reflected approximately 23 to 25 per cent of the agency's child maintenance budget per year. The OCA wanted to further explore this cost factor.

Finally the mandate of the OCA review was to look at the quality of care and the factors that impact on that care. Cost does impact on care. It is not the intention of the OCA to complete a cost benefit analysis of the shelter system as this is beyond the scope of this review. Our intention was to determine the per diem cost of shelter care for children and youth and describe what is included in that per diem cost. To aid the OCA in its endeavors, IA was consulted.

The Findings of the Internal Audit (IA)

The IA report was completed in late October 2003. The report is detailed and thorough. The IA completed interviews with WCFS staff directly involved with the financial aspects of the shelter system; financial reports were reviewed and 11 randomly selected shelters were visited and their internal procedures reviewed. The shelter worker responsible for receiving the allotment cheques at each selected shelter was interviewed.

The IA concluded that "adequate procedures have been established to ensure a satisfactory level of control over expenditures in the shelter system and to provide reasonable assurance that expenditures are being made as intended."

Though the fundamental controls in place were found to be adequate, there were a number of issues regarding the implementation of procedures.

- The lack of formal procedures: "A formal procedure manual was not available for shelter coordinators to ensure a consistent application of procedures. Without formalized procedures and direction it is difficult for coordinators to ensure policies are interpreted and applied consistently."(IA p. 5). Each shelter coordinator is responsible for approximately five shelters. Part of their role is to ensure compliance with procedures and to monitor for compliance. "The degree of monitoring activities vary, such as the frequency and timing of visits to the shelters" the amount of time spent on monitoring expenditures, the frequency of staff meetings.

- The impact of casual and purchased-service staff: "No full time staff have been hired in the shelters for an extended period of time. This has resulted in some operational difficulty because of the extensive use of casual" or purchased-service staff. As reported by the IA:

  "...these staff are less familiar with shelter procedures than regular staff and cannot be utilized in more responsible positions relative to cash management. This has made it difficult for some shelters to fully implement procedures regarding banking and added other operational difficulties. Some shelters have limited access to cash for temporary and even casual staff". (p. 6)

- Other expenditures: Additional funds are available through 'disbursement' and have on occasion been used to purchase such items as bedding, appliances or food to deal with triple staff situations. There are no formal guidelines "to clarify the types of expenditures that can be funded by the disbursement process rather than the semi-monthly allotment" (p.7). Such guidelines are required.

- The allotments: The IA queried the agency about how they determined the monthly allotment rates for the shelters. IA was informed that the allotments were a blending of foster care and residential care rates; however, no formalized documentation was found that outlined the process the agency went through to determine the allotment rates.

  The IA then compared the rates in the shelter system to those rates found in the foster (general rates) and residential care system (level 4 group homes) in an effort to determine how the agency set these rates. The IA was not able to link the rates of foster care and residential care to those provided to the shelters.

  Allotments for children in the shelters were not based on age of child but the bed space of a shelter. Establishing rates for care premised upon bed space is contradictory to other funding models found in foster care, residential care and even within provincial income assistance (EIA). Foster care rates and EIA rates are contingent upon the age of children as issues of food consumption, personal care, activities, and other factors such as the purchase of diapers and infant formula may vary considerably between the age-groups. Further disparity existed in the shelters when funding based upon bed space is expected to provide for more than just the residents. For example, the current allotment for the funding of food is expected to cover the cost of feeding staff and residents, but rates are not adjusted to cover additional staff when they are required.

Within shelters, the ability to budget the allotment varies from staff to staff. Some are able to maximize the allotment through more effective purchasing and meal preparation, ensuring the allotment can accommodate the number of children and staff within the shelter. However, other staff may not have the skill set to maximize their allotment thereby resulting in staff and children competing for the same food.

The IA also found that:

> "the current allotment methodology forces some shelters to manage funds more frugally than others. Those shelters with larger numbers of children, doubled staff and/or teenagers with larger appetites have a more difficult time making ends meet. Shelter staff occasionally cope with tight budgets by temporarily 'lending' their own funds to meet needs until the next allotment cheque arrives or resorting to no-cost recreation or cheaper food" (p. 6)

Overall, the IA found that the agency has adequate procedures in place to ensure a satisfactory level of control. However, there still exist a number of inconsistencies in the implementation of the established control procedures. As found by the IA in their review of 11 shelters;

> "All shelters do not follow established procedures. Some have delayed implementation of procedures, such as setting up a single bank account with two PINs and others are not always doing a cash count and sign-over on shift change. Varying methods of securing cash were also employed, de-pending on the risks at individual shelters. While none of these inconsis-tencies increase risk materially, they do impact on the effectiveness of con-trols and efficiency of the shelter operation." (p.7)

The EAPD Budgetary Process:

> **"We are totally funded by government. We are funded to zero. Government picks up our deficit, so really what is the problem".**[7]

Part of the concerns raised to the OCA was the cost of the shelters and agency measures to try to reduce those costs. In our interviews with shelter coordinators and managers we asked about the budget process and were informed that, "overall there is no budget for EAPD or hotels. You get the bills, you pay them."[8] Senior managers informed the OCA that the budget process included taking into consideration actual expenditures; days in care divided by the average cost per day and consideration of new initiatives. The average costs of the days in care included all costs associated with a child's placement in the shelter. In the 2002 to 2003 shelter costs, the previous year's actuals were higher than the current year projections and the agency projected their budget on fewer days in care. As a result the agency went over budget by 63 per cent. As noted by the IA

> "Actual expenditures for 2002-2003 were approximately 63 per cent over budget. The 2002-03 budget for the shelter portion of the Short-term Placements program was established at a level 41.7 per cent lower than the prior year's actual expenditures. The estimated number of days care for 2002-03, which is the prime basis for the budget, was 35.5 per cent lower than the prior year's actual. The rationale for these reductions was not readily evident." (p. 4-5)

There was no agency analysis to support the projections, and in fact this decision resulted in the agency going over budget by an untenable amount. We found no valid process to determine the monthly allotments or even a realistic EAPD budget; at times budgeting was based on unrealistic assumptions (reduction of days in care), leaving the agency with little ability to effectively analyze or realistically project costs.

What is the Per Diem

As can be seen in Table 4, there are really three levels to a shelter per diem cost for the fiscal year 2002-2003. The first level would be considered direct costs associated with the care of a child in the shelter (basic care and staffing costs). The second level would be the indirect administrative costs associated with supporting the shelter system (supervisory and other administrative support costs). The third level consists of costs related to the child and would occur no matter the placement of the child. These costs are child specific but given the child's placement in the shelter can be considered indirect costs related to the placement.

TABLE 4

Cost of Care Shelter Analysis
Average Cost Per Day of Care
Fiscal Year 2002/03

Cost Category	Explanatory Notes	Amount	Average Cost Per Day of Care
Total days of care		44,990	
Direct Shelter Costs:			
Salaries and Benefits	1	$ 8,664,957	$ 192.60
Building Maintenance	2	660,074	14.67
Care Costs	3	656,199	14.58
Other	4	178,596	3.97
Child specific Expenditures	6	263,857	5.86
Closed/New Shelters	8	80,069	1.78
EAPD Dispatchers/drivers	7	274,889	6.11
Total Direct Shelter Costs as per WCFS Shelter Analysis	5	$10,778,641	$ 239.57
Other Direct Shelter Costs:			
EAPD Coordinators	9	675,000	15.00
EAPD Project Manager	9	83,500	1.85
EAPD Supervisor	9	66,000	1.47
EAPD Admin. Support	9	40,000	.89
WCFS Payroll Clerk	9	35,000	.78
WCFS Accounting Clerk	9	26,000	.58
WCFS HR Support	9	125,000	2.78
TOTAL	**10**	**$ 1,050,500**	**$ 23.35**
Adjustments:			
Child Specific Expenditures	6	$ (263,857)	$ (5.86)
Total		$ (263,857)	$ (5.86)
Total Direct Shelter Costs		**$11,565,284**	**$ 257.06**

Explanatory Notes:

1. Salaries and benefits for WCFS shelter staff and purchased services (temporary workers). At the time of review there were 188 regular workers (40 hours or more biweekly guaranteed) and 59 casual workers employed by WCFS.
2. Property taxes, mortgage payments, utilities, rent, property maintenance, capital improvements, including $47,954 at 36 Alloway.
3. Food, household supplies, recreation, allowances, gifts, taxis/shuttles, bus passes/tickets.
4. Telephones, cell phones, mileage, moving expenses, shelter furniture.
5. Direct shelter costs per WCFS financial reports for 2002/03 total $10,432,935. This amount is $345,706 lower than the total reported of $10,778,641 on the Shelter Analysis prepared by WCFS. The majority of the difference is an amount of $345,193 related to care of Level 5 children in the shelters. This amount is calculated by the WCFS and is transferred to the Exceptional Circumstances program from the shelter program for budget control and financial reporting purposes. The number of days of care related to the Level 5 children, 1036 days, is also excluded from WCFS financial reporting for the shelter program.

6. Child specific expenditures that are attributable to a specific child including per diem clothing, initial clothing, excess clothing, mileage/transportation, gifts, medical, therapy, education, child care support, and activities. Child specific expenditures totaled $263,857 in fiscal year 2002/03.
7. Actual Salaries & Benefits for EAPD Dispatchers/Drivers.
8. Costs relating to shelters where there were no days of care provided.
9. Estimated salaries & benefits amounts provided by the CFO of WCFS. The estimated salary and benefits for the supervisor is based on a full fiscal year while the supervisor position was only filled for a portion of the year. The salary & benefits for the payroll clerk (1 FTE), accounting clerk (.75 FTE), and HR support (2.5 FTE's) are estimates provided by CFO of WCFS of the portion of time that these positions spend on shelter related activities.
10. A portion of other direct shelter costs could be allocated to the hotel portion of the program as these positions provide services related to hotel placements. One coordinator is responsible for hotels. We did not attempt to make any allocation to hotels.

According to Table 4, IA estimated that the average per diem cost was $257.06 per child. By removing the administrative support costs (salaries of coordinators, managers, accounting, and HR supports) and child specific costs which would occur no matter the child's placement (per diem clothing, mileage/transportation, gifts etc) the per diem rate is reduced to $239.57 per child. As well, if the costs associated with closing or opening of shelters are removed, the per diem is further reduced to $237.79.

The average per diem cost, therefore, associated with the direct care of a child and youth inside WCFS shelter system in 2002-2003 was **$237.79**.

This average per diem cost is based on actual days of care provided, the level of care needed, the number of staff employed and hours worked within the operational shelters that fiscal year. The OCA cautions the reader not to assume that this per diem can be generalized or compared to other care settings. All this per diem rate provides is what the agency spent on days care within the shelters in 2002 to 2003.

LABOUR RELATIONS

The OCA quickly became aware through reports from staff and management[9] of the tension in relations between agency management and CUPE. These tensions appeared focused on the guaranteed shift configurations, specifically the 24-hour shift and the cost of labour. Tensions were exacerbated by possible loss of employment for staff in the agency, as the agency's moved to consolidate the shelter system in an attempt to control costs. The OCA was clear that the intent of the review was not to become involved in the labour relations issues. However, it quickly became apparent that at times, the quality of care received by children and youth in the shelters was impacted by the negative relationship between labour and agency management. It left the OCA little option but to explore the labour relations specifically as it relates to the quality of care provided.

Analyzing the labour issues or financial costs arising out of the collective agreement is beyond the scope of this review. The OCA will speak only to evolution of the staff management relationship and its impact on service delivery.

The Creation of a Service-Driven Contract

As the model was expanded across the agency's geographical service boundaries and then centralized under the agency's program boundaries, the pool of suitable foster parent caregivers diminished and more staff were used to provide care. The staff care model was used more and more in both the EAPD hotel/motel accommodations and the shelter system.

The agency attempted to replicate the perceived benefits of the foster parent caregiver model. The primary benefit of the foster parent caregiver model was consistency of temporary care through one primary caregiver. The agency introduced the use of 24-hour shifts in an attempt to reduce the number of caregivers a child could be exposed to when housed in a shelter.[10] The agency believed that the introduction of a 24-hour shift would "provide a quasi foster parent"[11] to care for children. The use of staff as "quasi foster parent" would limit the number of caregivers a child would have and allow the adult caregiver the opportunity to built relationships with children in their care thereby ensuring a consistency of care, albeit temporary care.[12]

Increased problems with ensuring an adequate supply of childcare staff emerged as the decrease in suitable foster homes required more and more staff to meet the demand of childcare. These individuals were not permanent staff of WCFS but rather individuals who accepted casual "contract assignment." The contract was based on the care of an individual child or group of children. Once care was no longer required the contract, in essence, ended. The contract was not for the duration of time that child or children spent in care, but often just filled a shift. The EAPD system was premised on the belief that care was provided on a short-term emergency basis and therefore staff would only be required for a brief and transitory period.

Individuals who accepted contract assignments were often left without a source of income between assignments. As a result, many found consistent employment elsewhere. Further, these individual contracts did not allow the agency to dictate work assignment or allow the flexibility of moving staff to needed areas. The agency began to rely heavily on purchased-service agencies to fill the gap that again was emerging in the EAPD system. This practice proved very frustrating for the agency and led management to question why private purchased-service agencies were able to recruit and retain a dedicated workforce but WCFS was not.

WCFS also found itself moving away from the basic premise on which the shelter system was built - consistency of care provided by a single primary caregiver. Filling contracts on a shift by shift basis led to situations where a child could experience several caregivers, particularly if they remained in emergency care for longer periods of time. Agency senior management believed that the use of casual contract staff needed to be formalized to allow them to develop a dedicated workforce. They attempted to do so through the development of a collective agreement. The purpose of this was to make a "philosophical shift" in their labour utilization practices, from use of contract/casual staff to one where staff would now be permanent employees of WCFS. Senior management believed this philosophical shift would move the entire agency "to think about getting workers attached to the (agency) workforce and hence committed to the job and the kids."[13]

WCFS entered into negotiations with CUPE Local 2153, the union that had historically represented the agency's support workers and now represented the EAPD staff. Individuals who were in senior management at the time said the agency's goal was to create language in the contract that would support 24-hour shifts and therefore embed in the contract the agency's service philosophy of consistency of temporary care provided by a single caregiver.[14] The contract would also create a permanent and dedicated workforce.

However, sometime in 1998 the Manitoba Labour Board began dealing with an issue that would impact on the language of the contract. Overtime pay was the crux of the complaint(s). The agency then paid the 24-hour shifts based on bimonthly pay periods. Eighty hours were to be paid at regular time and any additional time worked, to a maximum of 26 hours, was paid at an overtime rate. After that maximum was reached, additional work was paid at a flat rate. For a 24-hour shift worker this meant that they would work four 24-hour shifts and one 12-hour shift in a 14-day period. Any time worked in excess of the 106 allotted hours would be paid at a flat rate. The Employment Standards Branch conducted an audit and found in favor of the employee(s) who originally laid the complaint. A compliance order was issued which required the agency to pay overtime to the 24-hour shift staff. Adherence to the compliance order would have required a pay out of $400,145.00.[15]

The agency senior management, knowing or suspecting the position of the Standards Branch, moved to guarantee "regular ongoing employment to EAPD support workers in accordance with established shift schedules."[16] This meant that shelter employees, if qualified, were guaranteed shift configuration of either 12 or 24 hours for a guaranteed prescribed number of shifts.[17] Though they were guaranteed their shift configurations they were not guaranteed their location of assignment.

The negotiated agreement provided compensation to 24-hour shift staff at the following rate: eight of the 24 hours to be considered regular hours and paid at straight time; eight hours to be paid at overtime rates and eight hours (or part thereof) would be considered personal time and a flat rate of $25 would be paid. The flat rate was to pay for 'sleep time' but also recognized that staff often had to "get up in the middle of the night" when working at the shelters. If staff were required to work more than two hours of their personal time the excess would be paid at the overtime rate of time and one half.

Upon CUPE's ratification of the agreement, the Employee Standards Branch agreed to withdraw its compliance order involving paid overtime for the 24-hour shift staff. Further, a financial settlement was reached and agreed to by all parties "in the amount of 15 per cent of the total amount identified in the audit." Agency senior management reported to their board that if all of the current employees accepted the settlement the cost to the agency would be $20,492 as compared to $400,145. The new collective agreement saw "resolution of the outstanding dispute involving payment of the 24-hour shifts and compliance with Employment Standards."[18]

The new collective agreement did create a permanent workforce and as the agency believed, enshrined its concept of stable and consistent care through a single care- giver by the creation of 24-hour shifts. Although the signing of the contract saw immediate short term saving for the agency, it did have future implications on the quality of care provided to children and youth in the EAPD system.

The Breakdown in the Relationship

> **"We called it a short-term system and hoped it would go away. It never went away."[19]**

Setting the Stage

Throughout the development of the EAPD program the agency attempted to create consistent care to children in a temporary and transitory placement. In order to facilitate consistency of care, the agency established a permanent workforce with guaranteed shifts and hours of work. A dichotomy exists within the permanence of a workforce whose nature of work is transitory and temporary. The EAPD was not intended to be a permanent part of the agency's scope of services, nor was its workforce. Consequently, the response of management was to treat shelter staff in accordance to the nature of their work. As stated, in the CUPE 2003 report, Investigation into the *Shelter and In-home Support Systems of the Winnipeg Child and Family Service Agency*, support workers felt "treated as non-persons within the WCFS system" (p. iv).

The feelings expressed by EAPD staff have a history dating back to 1998. Before 1998 the total bed capacity of the shelter system was 72 beds in addition to utilizing high cost hotel/motel placements. Simultaneously, the Prairie Research report recommended an immediate and detailed study on the cost effectiveness of the "various care options" and the development of a resource development strategy with emphasis on functional responsibilities (p. 109). Under the direction of a new CEO, the agency moved to reorganize to a Program Management model in 1998.

During this time the senior management was attempting to merge four geographical areas that were represented by the two separate and philosophically polar collective agreements, MGEU AND CUPE. The Program Management model required an organizational shift of a majority of the agency's labour force which would potentially be hindered by having two separate bargaining units for the same workforce. Consequently, senior management wanted to merge the CUPE and MGEU collective bargaining units, excluding the support/EAPD worker component, and negotiate one contract as the majority of the collective agreements expired. Employees represented under the main bargaining units of CUPE and MGEU were allowed to vote on union representation. Following the vote the majority of direct service staff folded into MGEU, while the EAPD and support workers remained represented by CUPE.

The rationale was that the uniqueness and transitory and temporary nature of their work made it impossible to effectively meet their needs under a master agreement. The underlying reason for the exclusion may have been justifiable; however, it served to further isolate support and EAPD staff from the process. Many in the CUPE membership saw management's intent to exclude them as a sign that their needs were secondary. Senior management at the time did not intend that message, but this indirect exclusion of line EAPD staff from the agency's ongoing reorganization validated the feelings of many of the support and EAPD workers.

This process also unintentionally created a perceived hierarchy between the two bargaining units. EAPD/Support staff felt overshadowed by the needs represented by MGEU, and through their union began to 'push the envelope' in efforts to bring their needs to the forefront. CUPE's push for recognition was often viewed as adversarial and uncompromising by senior management, thus perpetuating the polarization between the two groups that still exists today.[20]

The Impact of the Program Model

Lack of Human Resource Support

The Program Management model contained, under the responsibility of one program manager, the Resources in Support of Services program, which housed EAPD. With the signing of the collective agreement EAPD had 200 employees, 90 of them working full time.[21] By 2003, EAPD employed 193 permanent staff and 59 casual staff covered under the CUPE contract.[22] It should be noted that Resources in Support of Service Program was also responsible for additional programs[23] employing 200 MGEU staff and an additional 200 CUPE Support Workers. At any given time the program manager was responsible for approximately 600 staff.[24]

The Resources in Support of Services program operated under two collective agreements with two unions, MGEU and CUPE. The Human Resources (HR) requirements to support such a large program were never fully realized by the agency or by government. It was reported to the OCA that in 1999 the agency made a request for an additional HR staff position to be dedicated to the EAPD program and this was denied.[25]

Under Program Management, HR was its own department, working from a head office and responsible for all direct service staff, except for EAPD staff. EAPD was responsible for its own HR function, except for contract negotiations and grievance procedures. As the EAPD HR function was decentralized from the agency's HR program, personnel files were located at a field office that housed the Resources in Support Services Program. The lack of HR function for EAPD resulted in inconsistent keeping of records and the lack of immediate access to these records by the Director of Human Resources. The HR function, by default, became the responsibility of a shelter coordinator. Shelter coordinators were provided with HR training in the beginning but as coordinators changed or were added there were minimal training opportunities. More than 90 per cent of the shelter coordinators interviewed by the OCA cited a need for further training in appropriate supervisory skills, including their HR role. Eighty one per cent of the shelter coordinators interviewed rated the training opportunities provided to them by the agency as poor or very poor.

The shelter coordinators were required to understand, interpret and implement the EAPD workers' collective agreement in the daily operations of shelters. But with little support or training, issues began to emerge. CUPE officials told the OCA that as coordinators were added the "skill level changed." According to CUPE officials, the agency was promoting people from shelter worker level to coordinators, but provided little training in supervision.

The failure of WCFS to provide or include EAPD within the functions and responsibilities of the Human Resource program impacted on the EAPD program's recruitment, retention and supervision of its workers. Consequently, the poor labour management relations were perpetuated.

The Isolating Nature of the Work

The nature of the work inside the shelters created major obstacles in the supervisor/worker relationship. Shelter workers are extremely isolated from other agency functions. They work often individually or in pairs in homes situated away from the other agency offices and staff. Many work evenings, overnight, weekends and holidays when the majority of other staff in the agency are off. Shelter staff had no access to the agency computer system and therefore could not access its internal electronic communication system. Staff meetings were not routinely held in the shelters and when meetings were held they occurred during the day time hours, Monday through Friday, thereby barring full staff participation. Shelter workers had to rely on the shelter coordinators to communicate almost all agency information and activities to them. Forty-eight per cent of the shelter staff interviewed by the OCA cited a lack of communication between coordinators and workers as a concern in their staff/management relationships.

The Lack of Supervision

Supervision of the shelter staff also became an issue in the program. Shelter coordinators are housed in an agency office and not in the shelters they supervise. Shelter coordinators work Monday through Friday, 8:30 to 4:30. There is an absence of regular nighttime or weekend supervision. Shelter staff interviewed by the OCA reported receiving weekly (24 per cent), biweekly (32 per cent) or monthly (12 per cent) supervision. Thirty-two per cent reported never having received supervision. Ninety per cent of the shelter coordinators stated to the OCA that they provide supervision, usually on a weekly basis (54 per cent) in the morning (90 per cent) or afternoon (100 per cent). Only one shelter coordinator offered that s/he supervised staff in the evening.

The size of the EAPD program, failure to provide HR support, the lack of supervisory training, the lack of routine supervision across all shifts and the isolating nature of the work all added stress to the shelter worker-supervisor relationship. Many of the relationships between shelter coordinators and shelter staff were tenuous at best and breaks in that relationship were now played out upon a stage already set, the adversarial relationship between senior management and CUPE.

"The Government Take Over"

Between 1998 and 2001, WCFS was under considerable pressure to be more fiscally accountable and responsible. WCFS management and board minutes reflect concerns about the rising costs of the EAPD program. Compounding this pressure was the OCA's May 2000 report on the agency's use of high-cost hotel placements. During this period, there were two major changes in the composition of WCFS board while the agency continued to post increasing deficits. Not surprisingly the board dictated a shift in service direction which emphasized fiscal issues.

In August 2000, the AJI-CWI process began. At the same time, there were changes at the top. The agency's CEO resigned and the Director of Programs was charged with agency leadership until an acting CEO was appointed. The board changed again when the government announced its "take over" of WCFS. The government appointed an interim board on November 16, 2001.

Within the government press release, the department stated:

> "...a decade of financial difficulties—in which the agency's expenditures rose by nearly 90 per cent despite an almost 20 per cent drop in case load—made it necessary for a change in governance...the province must take steps to control the fiscal resources of the agency which receives 70 per cent of provincial CFS funding...with the implementation of the AJI-CWI, it was time for a significant change for WCFS."

The implications of these larger system initiatives had a negative effect on the labour relations' environment within WCFS. EAPD shelter workers advised the OCA through their union and in personal interviews that they have been told by management that the deficit of the EAPD program was the causal factor in the agency's take over. It would appear that either management never conveyed directly to this group of workers that the merger of WCFS into the government's regional structure was also part of the larger AJI-CWI initiative or the members did not clearly understand this message.

The agency's senior management began to address issues of staff dissension and anxiety about job security and redeployment to the anticipated authorities, by way of organized meetings with direct service workers represented by MGEU. These meetings also included the EAPD coordinators as part of the MGEU bargaining unit. Past practice had been to rely upon EAPD coordinators to transmit pertinent agency information to shelter workers. Given that the coordinators had no formal mechanism by way of staff meetings or technological communication devices in which to relay this information, the OCA believes that this information was not uniformly passed on. The lack of coordinated information-sharing left CUPE staff feeling further removed from this process. EAPD shelter workers began to receive fragments of information from other sources including agency direct service providers that only fueled their anxiety. The isolation and distrust felt by the EAPD shelter workers were heightened when the union, and subsequently EAPD staff, believed they were advised that they would not be part of the overall AJI-CWI service plan.

As a result of the recommendations of a report[26] commissioned by the agency new CEO on the EAPD program, the senior management and agency Board began the process to consolidate the EAPD program in January 2002. Consolidation was to increase fiscal responsibility and improve service through the reduction in operations of the EAPD shelters. The reduction in shelters was to be achieved through, among other initiatives, the amalgamation of some smaller shelters to larger shelters, non-renewals of long-term lease agreements, staff redeployment, and anticipated staffing layoff.

Board motion IMB0030 brought forward by senior management and carried by the board saw the agency promote a senior manager to "spend several months full-time overseeing the EAPD in order to implement recommendations, consolidate facilities and staffing, and bring coherent direction to the EAPD."[27] At this same board meeting, it was noted that a number of independent initiatives had taken place in an attempt to address the shelter issue by creating alternative care options with community-based agencies. It was suggested that these initiatives be merged into a single common approach. Board Motion IMB0031 specified that a "joint shelter committee (the Agency and the Directorate) be created, co-chaired by" the then president of the Interim Board and the Director of the Child Protection and Support Branch "to oversee the co-ordination of all shelter/hotel strategies and have the authority to take action and/or make decisions in dealing with collateral organization."[28]

The March 2002 terms of reference for the joint Agency/DFSH committee stated that in addition to creating alternative resources the committee would "develop and oversee implementation of a plan to consolidate short-term placement facilities to ensure the best quality care is provided in a cost-effective manner."[29]

The January shelter review also pointed out that the agency was operating and opening shelters without the prerequisite licenses. A number of the shelters reviewed were never licensed and could not be licensed under the new licensing regulations. Both the DFSH and interim board expressed their grave concerns about the operation of unlicensed facilities. By March 2002 the DFSH ordered WCFS to no longer place children in any newly-created shelter until all licensing requirements had been met. The agency was also provided a time line to resolve all outstanding licensing issues.

The consolidation plan began between March 2, 2002 and June 30, 2002 with the closure of 12 facilities, eight of which were ineligible for licensing. By October 2002 an additional two shelters were closed. WCFS also began to develop plans to create four six-bed shelters (two for children under 11 and two for youth over age 12). The move to further amalgamate three- and four-bed units to six-bed units was based on the agency desire to "provide more cost-effective service" and also to improve the quality of care. It was hoped that larger shelters would accommodate sibling groups and the reduction of homes would allow for more on-site supervision of the staff. With fewer homes the agency knew they would require fewer staff but felt that they would be now better able to make a "greater training commitment to these core staff."[30]

During this same period the joint committee was working with community agencies to create alternative care resources for the agency. According to the agency and the DFSH, 75 alternative beds were created in foster and residential care. This apparently offset the loss of 38 shelter beds.

Consolidation plans were now under way. Implementation was made complicated by the collective agreement, specifically the articles respecting the 24 and 12 hour shift configuration and guaranteed shifts. Consolidating shelters required the redeployment of staff. More importantly the fiscal realties of the guaranteed shift configurations were in the agency's opinion "driving up the costs of care." As stated in a May 21, 2002 WCFS issue note:

- "These guarantees restrict management's ability to schedule staff to meet changing needs."
- "They also set into place a requirement for the employer to pay the guaranteed income regardless of the amount of work performed."
- "The 24-hour shifts restrict the number of children that can be placed in a shelter as staff working 24 hours must be provided a bedroom under labour law."
- "The 24-hour shift restricts development of shelter for teenagers as facilities for teens must have staff awake overnight. The majority of shelters are licensed for children 11 years of age and under and teens have often been placed in hotels."
- "In the 2002-2003 Collective Agreement, salaries of child care support workers increased substantially and are considerably higher than salaries of child and youth care staff in child welfare treatment services. All 24 and 12-hour shifts require the payment of overtime."
- "While the hourly rate in the agreement is consistent with industry standard, the fact that staff are guaranteed 24-hour and 12-hour shifts results in an extraordinarily high annual salary."

The agency also determined that 12- and 24-hour shifts were not necessary in the new shelters and in fact might hinder the development of larger shelters. The agency, however, was obligated no matter the work site to honor the collective agreement and soon found it difficult to move staff to the new shelter sites while guaranteeing shift configurations and prescribed hours.

The amalgamation of shelters also recognized that the agency had shifted its service delivery from one based on single caregivers to one that was now more reflective of residential care. This shift appeared to have been influenced by the requirement to license shelters under residential care guidelines. Shelter care could no longer be considered to be quasi-foster care. The managers now in charge of amalgamating shelters also had extensive background in residential care. The agency which had once argued that guaranteed shifts would ensure stable and consistent care through a single "quasi foster parent" caregiver soon realized that this model was one it could no longer afford given government pressure to curtail and contain costs. As stated by the agency:

> **"it is prohibitively expensive to provide shift-staff care for small number of children. WCFS must re-develop six-eight bed receiving homes."**[31]

The Line in the Sand

Redeployment of staff became the "line in the sand" between staff and management. Consolidation meant redeployment.[32] A shift from a single caregiver model to a residential care model coupled with cost containment, meant possible layoffs for not only shelter workers but also shelter coordinators.[33]

Shelter staff and coordinators were informed of the consolidation plan. However, much of the information was relayed between shelter coordinators and shelter staff. When staff began to raise questions, shelter coordinators who were equally at risk in the process of consolidation often did not have the information or, given their supervisory styles and schedules, were not available to shelter staff. Staff and CUPE were untrusting of coordinators and the agency management, accusing coordinators and management of "lying" and management of fiscal mismanagement and questionable service delivery to children and youth that placed children and staff at risk.

Staff and their union resisted consolidation in the only means they believed was open to them - the filing of grievances under the collective agreement. Between May 2001 and April 2003 an unprecedented 55 grievances were filed.[34] CUPE reported from January 2002 to April 2003 that the union itself launched an "unprecedented eight grievances on the path to arbitration."[35] The grievance process took over management's time and energy from shelter coordinator to Program Manager. Shelter coordinators, ill equipped to deal with HR issues, often failed to provide their agency with appropriate documentation to support the agency's position. The agency's HR program in head office was inaccessible to the line coordinators and was often unaware of employee conduct issues until after a grievance was filed. Shelter coordinators soon felt powerless to deal with any staffing issue for fear of a grievance and abandonment by their management, as there was a general feeling that management would not support them in dealing with staffing issues.

The management and CUPE relationship, already adversarial, completely broke down. During this time there were a number of sensitive case and program information 'leaks' to which the agency and government had to react. Soon the agency's adversarial relationship with CUPE extended to the interim board. In one instance the interim board president publicly questioned the veracity of the leaked information, stating that no one had come to him with the issues raised. When questioned about this by the OCA, union officials stated they were told by management that going to the board president was a "breach of Section 76 of the CFS Act." They said they felt they had no choice but to now raise concerns outside the agency as no one in the agency was listening. Union officials told us that they were now advising their members to notify outside organizations, such as the OCA, of any concerns in the shelter system. True to their word during the life of this review the OCA did receive numerous calls from shelter staff; their primary complaints, however, were about labour management issues and not service delivery.

It was also reported to the OCA that the board and DFSH officials were aware of the adversarial relationship between the agency management structure and union. The interim board president invited the union to attend board meetings, and some union members did attend. As well, the board president and senior DFSH officials met separately with the union to begin to address their concerns over the consolidation plan.

The union's opposition reached its peak with their release of their April 2003 report, *Investigation into the Shelter and In-home Support Services Systems of the WCFS Agency*. The relationship now was completely broken down. The coordinators, staff and more importantly the children and youth were caught in the middle.

The Impact on Care

The OCA interviewed 25 shelter staff and 11 shelter coordinators. Overall, the shelter staff were well qualified (four per cent had less than a grade 12; 16 per cent completed a grade 12; 52 per cent completed grade 12 and had related training at a community college level; 28 per cent held a university degree in a social science related field) to complete their job functions. Shelter coordinators were also well qualified; 55 per cent held a university-related degree, and all had childcare related experience. To the OCA, shelter staff and coordinators interviewed all appeared genuine in their commitment to their chosen field.

Of concern to the OCA was the negative and at times antagonistic environment that many staff reported to have impacted on their capacity to carry out their job functions. Shelter workers reported feeling under valued and not respected by the agency. As stated by one senior shelter worker, "they (management) feel we are over paid babysitters."

The majority of shelter coordinators felt unsupported by agency senior management. Many expressed their concern to the OCA that they were often "caught in the middle" between agency management structure and staff. All stated they did not feel certain that they had effective and consistent management support, including their HR department, when dealing with staff issues. Some shelter coordinators expressed their fear that following the OCA review, they would become the "sacrificial lambs" in the management's response to this review.

Shelter workers have limited knowledge of the agency or department's management structure. Ninety-six per cent identified shelter coordinators as management when discussing staff management relations. Seventy-two per cent cited this relationship as poor or very poor. None of the shelter workers could identify management layers between the agency CEO and board and their individual shelter coordinators. Overall, shelter workers could not identify such individuals as the program manager or project manager, who make decisions about shelters and may be persons they could seek assistance from. Generally shelter staff are isolated from those in positions of authority inside the agency.

Fifty-four per cent of the shelter coordinators described their relationship with shelter staff as being good. Of interest 45 per cent of the shelter coordinators cited their relationship with management as good to very good but an equal percentile, 45 per cent, cited this relationship as being poor. Shelter coordinators identified management as middle to executive management positions (project manager, program manager, and Board). Shelter coordinators were quick to point out that any perceived problems in their relationship with management were not due to personalities but more due to the change in direction the agency was taking to consolidating EAPD. As one shelter coordinator stated:

> **"It's our job to maintain these homes, so we are now at cross purposes with the WCFS. I think the agency views us as a problem. They (WCFS) want other agencies to come in and scoop up the emergency services. I don't think the agency views us as part of the team."**

Of consistent concern to the OCA were the negative impressions that some managers (middle to executive) expressed about shelter staff and more specifically of the elected union officials. Managers have described shelter staff as "unskilled", "untrained" and "over paid." They have described union tactics as "uncompromising" and "self-serving." Only one executive manager expressed concern that her general comments to us about perceived shelter staff' limitation might affect staff morale. Generally, however, the OCA found managers displayed an openly negative attitude towards shelter staff and their union and a blaming attitude toward shelter coordinators and past agency managers.

Shelter workers and coordinators appear now to have an unhealthy suspicion of one another. Shelter coordinators feel caught in the middle, and unsupported by management. Managers feel blamed for decisions made in the past when many were not in their current positions. Many in turn say they have felt unsupported by the DFSH when they were attempting to deal with the resource crisis that resulted in the creation of the shelters, a resource crisis which still exists today.

One senior manager provided an assessment of the staff management relationship that has emerged over the years:

> **"There is mistrust on both sides. We have senior managers who have no experience working in a union environment. So management gives in. The last collective agreement was like that. Management believes you can 'buy' good management/worker relationships. 'Here', management says 'I'll give you everything'. And when there is a problem management acts shocked, dismayed and hurt. So what do we do now, we re-sign the contract. ...The staff management relationship has become an engrained culture. Throw money at staff and then they will be 'good.' Staff say 'give us money and we may be good.'"**

The negative and antagonistic work environment has a trickle-down effect into the shelters. Many shelter staff, under stress, appeared to children and youth as angry and judgmental. Shelter staff who raise concerns about individual children and youth and or other staff do not feel heard by agency management. Shelter coordinators, who rightfully want to deal with questionable child management techniques used by a minority of staff, often feel they cannot. Questionable staff behaviour was not seen to be dealt with in an effective manner as the program has limited HR support. There is a general belief that once the agency attempts to deal with staff behaviours, grievances are filed.[36] The union position in representing these staff is often seen by the agency as part of an uncompromising stance. The general impression is that problematic employees are simply moved from shelter to shelter as the agency cannot "win" grievances. As stated by one agency manager:

> **"I have no ability to hire or fire. I can send staff home with pay but that's it. Everything goes to HR. There are people who should not be working with children. (Manager describes two incidents of staff misconduct to OCA) We went through the process but it is long and cumbersome. HR tells us we cannot fire these people because we do not have cause. We either did not document or timelines were not met. Eventually coordinators give up, other staff gives up."**

As did managers and coordinators, shelter staff complained that there is a minority of staff who simply should not be caring for children. They expressed frustration that many of these staff persons are still employed. The OCA was told that any attempt to deal with problematic staff would result in a grievance as the union is "grieving everything."

Union officials interviewed by the OCA said they too are concerned about certain staff but felt the fault lay with the agency and the lack of HR training and support to shelter coordinators in dealing with these issues. Union officials also pointed out that the agency needed to work co-operatively with the union but does not do so, adding that the "management's style is to refuse to deal directly with HR issues."

Conclusion: Our Collective Responsibility

The literature would suggest that:

> "Weak leadership is strongly linked to feelings of isolation, frustration, stress and burnout at direct service and supervisory levels...There is strong evidence that open and caring relationships, guidance, partnership and empowerment of staff are important elements in retention. The feeling of belonging to a community and having a solid peer support network at work reduces burnout at a management level and front line levels. Too often this feeling of community is absent in agencies, where communication, support and recognition are undervalued.[37]

Certainly we see that the shelter system as it exists today is not part of the WCFS community. We have seen that there are problems with communication, support and recognition at all levels in the shelter system. Agency management (from coordinators to board), CUPE and shelter staff have clearly lacked a true partnership in service delivery and now this lack of partnership may extend to government, as the agency is now a branch of the DFSH.

The staff, union, managers and the DFSH must now, if the environment and services delivered in that environment are to improve, enter into a new partnership. The agency and the DFSH certainly have a 'corporate' responsibility to move in this direction. CUPE has in presentations to the OCA and the public said that one of its primary concerns is the welfare of the children and youth inside the shelter system. The OCA has no doubt of the genuine nature of their expressed concerns. They too, however, have a responsibility to now enter into a new partnership to improve the relationship, the environment and ultimately the care of the children and youth their members serve.

The Child and Family Services Act is clear: the best interests of children and youth shall be the paramount consideration in all actions taken under the *Act*. The delivery of services, the quality and impact of those services are clearly actions taken under the *Act* and therefore must be taken with the best interests of children and youth in mind.

The Consolidation Plan

As we entered this review we became aware of tension surrounding what was called the Consolidation Plan (CP). When we first asked WCFS about the plan we were informed that there was no overall written strategic plan "but a lot of little plans". The CP began in 2002 and appeared to involve a series of actions planned internal to WCFS with respect to the EADP system and resource development plans initiated externally by the DFSH. Over a period of time these were was formalized under one larger strategy.

It would appear that there were three primary initiatives of the CP, the first involved gaining administrative control over the EAPD system. The second involved the development of alternative resources in the community with community partners. The third concentrated on coordinating case planning for children and youth that appeared to be in limbo while placed in emergency care.

Each initiative appeared to begin separately but as DFSH senior officials became more involved through the Joint Planning Committee, these independent initiatives were formally linked. Prior to the development of this committee the CP was viewed, outside of the agency's management, as primarily the amalgamation of the shelters to reduce costs. Over time, the CP clearly has developed into a larger service strategy involving the creation of alternative resources outside the shelter system.

The CP, though now a service strategy encompassing more than the shelter system, is and was not well understood (at the time of this review) by the majority of shelter staff, coordinators and to some extent managers. The belief of many interviewed is and was that the CP meant the amalgamation of smaller shelters to larger shelters. Clearly it is a much larger strategy that encompasses more than simply the EAPD shelter system.

Administrative Control

WCFS staff stated that the CP was first an attempt to reduce "duplication" and streamline administration of the EAPD system. The agency moved to amalgamate some of the smaller shelters into six bed units, and planned on placing supervisors' work sites into the shelters. The reason for the integration of supervisors in the shelters was premised on the belief that larger staff groups and on site supervision would break down "staff isolation." The OCA asked if the agency's amalgamation plans were based on a program evaluation of EAPD, an identification of and needs assessment of the population to be served, and/or cost analysis of the intended six bed units. The OCA was told no.

Agency managers told the OCA that six bed shelters would be more cost effective and would allow for more streamlined administration. It was believed that the quality of care inside the six bed shelters would improve, as staff would be better supervised and the agency could then free staff time (provide shift coverage) to allow for more training. Staff shifts would be re-configured to eight-hour shifts. Finally, the agency stated that the larger units would be more flexible in dealing with larger sibling groups.

Within individual interviews of shelter staff, coordinators, managers, and social workers, the OCA asked "Given the opportunity, what would you change about the shelter program to better meet the needs of children and youth?" None of the shelter workers cited larger shelters as an option. They did, however, cite increased and regular supervision and additional training as key components for change. When shelter coordinators were asked the same question the majority cited the need for better staff training, eight-hour shifts and on site and available supervision. However, the shelter coordinators stated that smaller units (three to four beds) would better serve the needs of children and youth.

It appeared to the OCA that originally the amalgamation of some of the smaller shelters to larger shelters by the agency was to address the administrative problems within the shelter system and curtail costs. Little analysis appeared to be completed to assist the agency in understanding the impact on the direct care of the children and youth of moving to six bed units. This was and is the primary weakness of the agency's amalgamation efforts.

The OCA found that the primary population of the children entering into the shelters was ages 0 to 11 (60 per cent). Of these, 25 per cent were under age 3. In our opinion emergency group care is not in the best interests of younger children ages 0 to 7. As well, larger emergency residential units are not in the long term best interests of children and youth ages 8 to 13.

Certainly the agency's attempts to improve supervision, streamline administration and reduce shift to eight hours is admirable. However, the planning of larger shelters appeared to be based on the administrative needs of the agency and a desire to reduce costs and not on detailed knowledge of the population of children being housed and their developmental needs.

The Development of Alternative Resources

In March 2002 the agency and the DFSH entered into partnership through a Joint Planning Committee (JPC) that would develop and oversee the implementation of the CP and ensure quality of care. This was to be done in a cost-effective manner. The JPC was also given the authority to create alternative care resources in the community. Funding for these resources was to be diverted from the existing EAPD system.

The DFSH believe that the JPC, has been successful in creating community-based alternatives to shelter care. The OCA has no knowledge of these newly created resources and therefore will not comment on the programs. The OCA does, however, acknowledge the efforts undertaken by WCFS, the DFSH and concerned collateral community based agencies in developing alternatives for children and youth.

Our concern is a larger systemic concern as to how 'need' is established by our system when looking to create alternatives not that alternatives are created. According to senior DFSH officials the development of alternative beds was based on the "numbers" the agency provided and information from the Provincial Placement Desk. The Provincial Placement Desk responds to children and youth requiring residential group or treatment care. Their involvement with the shelter population would be restricted to older children and youth. Given that the majority of children are 0 to 11, the OCA questions if the information available to the agency and the DFSH is adequately rich in the detail required.

According to DFSH staff interviewed, resource development across the province is often done according to "the problem of the day" because "there is very little money dedicated to resource planning and development." As a result, "we design resources around specific population because we are in a crisis to find suitable placements".

According to the July 2003 WCFS Shelter Reorganization Plan, 214 beds (127 shelter beds plus 77 new alternative residential beds) will be available by March 2004. We believe this is admirable. However, the OCA cautions that proceeding without a full understanding of the population requiring services could make it difficult to adequately meet future resource needs.

Improved Case Planning

The Short Term Emergency Placement committee does not manage the EAPD system. It is designed to manage the population of children and youth placed in WCFS short-term emergency placement system. Its purpose is to ensure this population has comprehensive care plans developed on their behalf (improve planning for children and youth whose care plans appear to be in limbo). The STEP committee also tracks the number of children and youth in emergency care. This information is now provided to agency senior managers and officials from the DFSH. The STEP committee is a relatively new component to the CP and the agency believes it has reduced the number of day's children and youth remain in emergency care. The OCA is unaware if the STEP committee has produced the desired reduction in days of emergency care and would encourage the agency to evaluate their approach. The OCA, however, acknowledges these efforts made by the STEP committee.

PART 8: LINKING ASSUMPTIONS TO PRACTICES

At the onset of the review of the EAPD shelter system, the Office of the Children's Advocate in collaboration with the Shelter Review team developed a definition and qualifying assumptions about the EAPD program as an alternate form of emergency shelter care. Specifically, current provincial standards, Professional Standards of Excellence (CWLA) and relevant literature were used to guide assumptions about this program's definition, purpose and function. The following is a summary of the current EAPD system and their practices in relation to these assumptions of care.

WCFS- EAPD Shelter System

Linking Assumptions to Practices

Assumption	Practices
1. Based upon "Best Interests"	- The shelter system does not collectively meet the long term best interests of groups of children and youth placed therein, specifically young children ages 0 to 7; children and youth placed beyond 60 days. The mixing of age populations, 0-11 and 12-17 years in shelters cannot accommodate the varying developmental and social needs of these diverse groups of children. - WCFS social work staffs report that shelter placements are preferable in foster care or residential treatment due to their perceived stability. However, social workers also report hotel placement as a preferable placement choice, over shelter and foster, due to the ability to maintain sibling groups.
2. It provides protective substitute care for the child.	- Generally shelters serve to be a substitute care alternative that can be more protective than the child's home environment. However, the inappropriate matching of children/youth, their ages, developmental needs, and risk factors, within the shelters does not always ensure a protective environment. As well children, youth and staff report that the geographical location of the shelters can present safety concerns.
3. Placement in shelters are of benefi to the child.	- Shelter care can be of benefit to children who are quickly reunified with birth family after apprehension, thereby avoiding further movement along the care continuum. - Shelters can provide a care alternative on an emergency basis for families in crisis, or those of disabled children who are awaiting long-term treatment placements, and who can no longer provide care in the family home. - Shelters are not of benefit to children and youth who are without appropriate mental health resources, or suitable treatment care options and can often reside in the shelters for extended periods of time. The risks of placing younger children into emergency group care quickly can erode the immediate benefit of safety. - Youth who have experienced multiple care placements report that shelter care is more comfortable for them as opposed to foster or residential care.

Assumption	Practices
4. Provides basic necessities – food, shelter, clothing, medical, education and recreation.	Generally shelters provide the basic necessities for a child/youth care. However, care can be compromised by lack of available funds for complement of child-staff in home, the lack of adherence to agency procedures and policies in managing those funds and the lack of budgeting skills by some workers. - Children, youth and staff report school enrollment and attendance decreases significantly with shelter admission. - Children and youth report that although there is opportunity for informal recreation within the shelter, there is a lack of participation in structured and organized community recreational and cultural opportunities.
5. Staffed with qualified, competent, trained care providers.	- WCFS Staff interviewed by the OCA are competent and qualified by their own achievements in post secondary training, but lack further training relevant to work within the shelters. WCFS provides regular and refresher training in First Aid and CPR. NVCI training is provided, but only once. - The agency does not provide on going training in child development, risk issues, health issues, nor competency based training. - The agency relies on purchased services whose qualifications, training and supervision rests outside the agency. - Poor staff performance is not seen as being effectively dealt with by the employer.
6. Provides basic assessment of child's needs.	- Although coordinators reported and the initial program intent indicated that assessment of child's needs were completed, staff interviews reveal that assessments are not completed, nor do staff have any relevant training in completing assessments.
7. Transitional to other care – foster, independent living, kinship, other residential care or home.	- The shelter system primarily services children who are entering from another form of alternate care (specifically foster care). Of the 10.3 % of children entering into shelter from family or community. It has been reported that transitional planning and pre-placement visits typically do not occur, and are not permitted in the majority of shelters.
8. Time limited – 60 days.	- 38% of children and youth exit in 30 days. 60 % exit in 60 days. 40% remain 60+ days. Children and youth remaining long term (up to 271 days) cross all age groups.

Assumption		Practices
9. Home like setting is conducive to promoting healthy growth and development of child.		- The presence of shift staff is counter-productive to the concept of a home like setting. The use of purchased services and inconsistent staffing do not promote healthy attachments for child development, particularly in shelters housing young children. - Many shelters do provide a home-like physical environment, but this varies across shelter sites, with some shelters presenting as institutional. While some shelters are located in safe neighborhoods, children, youth and staff report that others are situated in locations that place everyone at risk.
10. Environment and program of shelter is conducive to ensuring connectedness to family and identified community.		- Family visitation policy and peer contact is not consistently implemented in the shelters. Families are discouraged and generally not permitted to have contact with the child even if sanctioned by the placing social worker. - There is no clear program designed for the shelter system. Programming, if available, typically revolves around recreation and is not conducive to ensuring any connection with family or identified community.
11. Compiles with minimal standards and regulations as set out in the CFS Act.		- Prior to 1999, shelters were not licensed. Initiation of licensing after 1999, saw the shelters as non-compliant with the guidelines contained within the required program statement under the licensing of residential child care facilities. To date, all facilities are licensed, but some are inconsistent in maintaining licensing requirements outside of their annual license inspection. - Currently licensing regulations speak to residential care but not emergency residential care. The regulations do not adequately cover this new form of care.
12. Shelters exist within programmatic boundaries, which defines purpose, policy, procedures, stated goals, objectives and outcomes.		There is no program model or stated goals and objectives with measurable outcomes. A policy and procedures manual exists for administrative functions, but most view this manual as a set of guidelines which are outdated or not kept up as new policies are developed.

Assumption	Practices
13. Program is accountable to authority, community and child.	- Between 1997-1999 there was an effort for inclusion and accountability to the community. The agency sought community sponsorships for creating cultural and community connections with the children through the Arts, athletics etc. There was an association and attempt to develop community-based programs. As the program grew and became licensed, there was an absence of community involvement in the further development of program. - The program is not accountable to the child or youth. No grievance procedures for children and youth. Nor is there youth participation in program development. - Agency fiscal management practices failed to adequately inform the funder of realistic need for program. - Lack of on-site supervision and the use of purchased service staff without ensuring adequate supervision impacts on the quality of care. - Poor staff/management relationship internal to WCFS EAPD has lead to antagonistic relationship between the two groups that can affect the environment of the shelters.
14. Community based which ensures access and linkages to schools, recreation and resources.	- All shelters are in the community however accessibility to resources is dependent on staff interpretation of rules, which then disallows ease of access. -School connection is continual problem for children and youth. Budget, staffing, and age complement in shelter limit recreational opportunities. No opportunities are provided for cultural or linguistic connection. Children and youth reported to being placed outside their communities (neighborhoods) away from their peers.
15. Staff – child ratios are flexible and appropriate at all times to meet individual child, and group need and situation.	- Currently WCFS report that the guaranteed shift configurations disallows the agency the flexibility to assign staff to needed areas. The, at times, inappropriate matching of children and youth and of children and youth to staff skill in shelters can prohibit the projection of appropriate child-staff ratios leading to situations of understaffing at the onset of placement. The appropriate staff complement is added once the child has resided in the shelter and an incident has occurred. - Youth reported that single staff in the shelter do not contribute to a home like environment, as youth are sent to their rooms when meals are prepared, during another youth's admission or discharge, or case conference. Youth reported to prefer 2 staff at all times to ensure that there are opportunities for interaction during these times, and so that they do not have to leave the home when staff have to fulfill other responsibilities.

PART 9: SUMMARY AND CONCLUSIONS:

Soon after the OCA's entry into this review we knew that we would have to complete an historical review of the EAPD shelter system. To complete a snapshot-in-time review certainly would have likely yielded many of the same conclusions but the systemic internal and external pressures that impacted on the program would not have been understood. Without understanding these issues, we cannot move forward in developing an emergency care system founded in best practice principles and designed to meet the needs of the children and youth we serve.

Throughout this review a number of general themes emerged which contributed to the development of the program we find today.

External Realties and Pressures

Aboriginal Children and Youth

One over-riding reality was the high number of aboriginal children and youth the shelter system serves. Historically aboriginal children and youth are over represented in the CFS system. It has been demonstrated through numerous studies that the CFS system has not well served aboriginal children, youth and their families. This is a fundamental reason for AJI-CWI. The shelter system affects the aboriginal community more than any other. In developing any new emergency care system we must be aware of the population it will primarily serve. Currently this system serves primarily aboriginal children and youth and their families living in the City of Winnipeg. In planning any new system we must be cognizant of this very fact.

In the WCFS EAPD system 62 per cent of the children and youth placed were aboriginal; approximately 43 per cent held treaty status. However, 83 per cent of children and youth placed in the shelters were aboriginal. Of the aboriginal children and youth placed in emergency care, most were under 11. Alarmingly, compared with non-aboriginal placements, a large percentage of these children were 4 or younger. As well when the OCA looked at the youth population we found that non-aboriginal youth (ages 12 to 17) were more often placed in emergency care other than the shelters, than were aboriginal youth.

Though the majority of all children and youth enter emergency placements from foster care a higher percentage of non-aboriginal children and youth come from foster care (61.5 per cent) than aboriginal children and youth (45.5 per cent). A higher frequency of aboriginal children and youth (35 per cent) enter shelters from hotels as compared to their non-aboriginal peers (17 per cent). Aboriginal children and youth are more likely to enter emergency care under apprehension than their non-aboriginal peers.

The data received from WCFS was limited in that it did not, among other information, completely capture aboriginal status. The OCA reviewed case files through CFSIS to gather information with respect to aboriginal status and other areas where information was missing. Despite our efforts information with respect to aboriginal status still could not be determined in 223 of the files reviewed. That it is extremely important that there be appropriate recording of the status of children is underscored as the child and family service system moves forward.

Providing care extends simply beyond basic care. It requires an understanding and full knowledge and appreciation of that child's identified family, community, culture and history.

The Resource Crisis

There is a national shortage of foster homes and other family based settings across Canada. More importantly to Manitoba there is a lack of culturally appropriate foster homes or family-based settings (see Appendix 2). It has been reported to the OCA in this review that the EAPD system and more significantly the shelter system grew due to the lack of appropriate alternative care resources. As well, WCFS reported that current residential and foster care resources will not take high-needs children or are returning children to the shelter system.

A majority of children and youth entering the shelter system are coming from foster care; only 8.5 per cent are coming from residential care. The EAPD system appears to be primarily supporting the CFS care system. This situation implies that our child welfare system is not able to support the care plans of children and youth already under its care.

It should be noted, however, that the shelter system accepts a large percentage of children from hotels, thereby reducing the agency's reliance on this unregulated and unlicensed care resource.

It is clear that there is a crisis in our foster care system. We simply do not have the foster care resources to match the needs, particularly culturally appropriate resources. This shortcoming should not come as a surprise to those working inside the CFS system. Certainly other reviews across Canada and more recently in Manitoba (Patrick Redhead Inquest Report) have pointed to this crisis. It is clear that the shelter system grew in response to the resource crisis.

Through the AJI-CWI process, our foster care system will be reviewed. It is our sincere hope that this process will begin to address a number of issues. It is not the intention of the OCA to complete a review of Manitoba's foster care system as others have made recommendations to government. Most recently Judge Linda Giesbrecht made a series of recommendations regarding foster care. The OCA would support the implementation of these recommendations in partnership with the Four Authorities.

The issue of whether children and youth enter the shelter system from foster or residential care is significant but what is more important and requires greater emphasis is the impact of such breakdowns on children and youth. That impact can often affect a child's future placements. The more placements a child must endure the greater the negative impact on the child's development. The question of why these breakdowns are occurring has not been fully addressed by the DFSH or the agency.

WCFS has only recently begun to track foster care breakdown and the OCA would encourage the agency to continue in its efforts. The OCA is unaware if the DFSH tracks residential care breakdowns. Such tracking would be advantageous to our system and most importantly to the children and youth living inside these care resources.

The Development of Care: What came first, the crisis or the resource?

The belief of many WCFS staff we interviewed was that the needs of children and youth are increasing. Resources have not been developed by collateral agencies to meet the current need, leaving the agency with little option but to create its own. Agency staff reported there is a shortage of residential care beds and that residential care facilities are restrictive in their selection process. Access to residential care beds is through the DFSH and the process was described to the OCA as at times cumbersome and at other times non-responsive. Line social work staff are often left scrambling to find the next best alternative.

DFSH staff interviewed maintain there is no evidence that residential care facilities are not taking high-needs children and that the centralized access to residential care ensures that every child or youth has an equal opportunity to receive services. DFSH staff, however, conceded that resource development is often designed to accommodate crisis.

Generally there appears to be no overall vision and co-ordination of resource development. Our CFS system needs to develop the capacity for community resource development for out-of-home care for children and youth in a systematic and planned fashion. Doing so will allow our system to:

- Identify current and projected resources needed by children, youth and families.
- Communicate and demonstrate to the community, policy makers and funders that the resources are needed.
- Obtain the appropriate level of financial support for those services.
- Develop a province-wide service capacity to meet the identified and projected needs within our communities.
- Monitor the services to assure that they effectively meet the needs of children and youth.

Admission to residential care beds from a centralized source can ensure equitable opportunity for access. However if the Provincial Placement Desk is only to vet placement requests and not assist in planning or quality assurance, it is little more than a reservations desk. The Provincial Placement Desk should become a multi disciplinary committee that will actively assist in planning for high needs children and youth. Social workers need to be brought back into this process and be afforded access to information about residential care bed openings. Such information can then be shared in a timely fashion with parents, children and youth who are involved in case planning.

Licensing and Monitoring of Care

The DFSH is responsible for licensing the EAPD shelter system. The shelter system operated for four years before changes in legislation (1999) required compliance with *Residential Care Licensing*. To expedite the licensing process of pre-existing shelters, the DFSH provided a level of latitude to the agency in the licensing process. Had the facilities been required to qualify for licensing at the onset and prior to any new facility opening, the level of scrutiny would have been higher.

The DFSH was clearly not ready to absorb the shelter system into the licensing process. The DFSH reported that in 1999, 27 shelters required licensing. By February 2001 the number of shelters requiring licensing grew to 67. During this time, the agency was attempting to create short-term resources while complying with licensing legislation, leaving the DFSH in the position of "catching up" in the process of issuing a license. The DFSH focus then became on getting the shelters licensed. The requirements of the licensing process became less stringent for the shelters.

Before the legislation changed, the concept of emergency residential care was not a concept well understood by the DFSH. While the issuing of a license does ensure that children and youth are not placed in unregulated care, the current standards do not adequately address the uniqueness of emergency shelter care. The EAPD care facilities are not always able to ensure consistency in adhering to a program description or program statements reflected in standards due to the continual changes in the population within each shelter.

Interviews with DFSH also reveal that the licensing process fails to speak to the issue of quality of care. Licensing standards and regulations are intended to operate as minimal guidelines. Quality of the home environment, log documentation, staff skill levels, programming and recreational opportunities are all left to the interpretation of the individual facility operator. There is no ability for the DFSH to ensure that facilities exceed minimal standards.

Currently the DFSH employs only one staff person to license all residential care facilities in the province, which now includes the shelter system. This same staff person also issues all the variances to the licenses and provides support to residential care in striving to create and maximize service goals. One staff person cannot adequately complete all annual reviews, variances, and monitor and provide support to all residential care.

In 1999 the DFSH created a Provincial Child Abuse Investigator (PAI). This individual is required to investigate allegations of abuse by staff, in all forms of residential child care facilities licensed by the Province of Manitoba, including youth correctional facilities. The PAI does investigate allegations of abuse inside the WCFS shelter system. The role, however, is limited to investigating only staff employed by WCFS and not purchased-service staff. When allegations arise concerning purchased-service staff, WCFS social work staff investigate.

The recommendations made in the PAI report are not consistently implemented and there is no process in place in WCFS to acknowledge the receipt of the report or respond formally to the investigator's recommendations. The implementation of the recommendations is primarily left to the individual shelter co-ordinator. The majority of the shelter co-ordinators interviewed stated that whenever possible the PAI recommendations are followed. However, if those recommendations have a cost factor or if the matter falls into the human resource area, and could be considered a disciplinary issue, they have no authority to act.

The role of the PAI is important and much needed. The PAI's can only focus on individual allegations and cannot be used to determine patterns or themes emerging in a specific shelter. The PAI role is primarily to determine if abuse occurred as defined under the CFS, a definition that is limited to an act or omission, which causes a physical "injury" to a child. Recommendations are restricted and cannot include any recommendations that would affect an individual's employment status.

As a licensing authority it is the responsibility of the DFSH to monitor the care children and youth receive and immediately investigate when allegations are raised. One staff position is insufficient to ensure adequate monitoring of care.

The System: The Purpose of Care

Child and Family Service agencies are required to provide a broad range of services to ensure the well being of children and to assist families in caring adequately for their children. Services should be immediately available, matched to the specific needs of the child and family and in compliance with relevant legislation, regulations and best-practice standards. Generally services are directed to achieve the following outcomes[1]:

- Children are protected from harm
- The capacity of families to protect and care for children is enhanced and strengthened.

- Children are removed from families only after reasonable efforts have been made to maintain the family unit.
- Children are assured high-quality substitute care, in stable child centered and family-like settings in their community when efforts made to maintain the families have not been successful.
- Children unable to remain in or return to their families are ensured a permanent home.

CFS agencies must have the capacity to provide care in a setting appropriate to the needs of child and family and provide a range of services to meet the child's health, mental health, education, social and cultural needs. Intensive services and vigorous efforts to reunify the family and child must also accompany out-of-home placement.

Several principles guide the provision of substitute care and include:

- Placement services should support long term service planning for the child.
- The parent-child bond should be maintained during placement until there is clear evidence that the parent cannot resume care.
- Placement should allow the child to remain as close to the family, neighbourhood and community as possible in the most family-like setting that can address the child's needs.
- Placement services require a working partnership among the child's placing agency/ worker, care provider, the biological parents and often extended family and community to most effectively meet the needs of the child.

The EAPD shelter system aimed to meet the principles of care. It was to provide emergency temporary care whose outcomes ensured that:

- Children and youth were adequately and immediately protected from harm.
- Superior care was provided in safe, nurturing home-like environments.
- Care was temporary and transitional.
- Children and youth were stabilized through the provision of superior care, which promoted healthy development.
- Children and youth were supported to maintain their connection to family and community.
- Children and youth were reunified with family as soon as reasonably possible.
- Children and youth if unable to be reunified moved logically to the next most appropriate substitute care resource.

The EAPD shelter system was to carry out a number of activities to ensure their outcomes were met. These activities included:

- Provision of superior care.
- Completion of functional assessments based on the individual child's needs.
- Provision of innovative programming to meet the child's identified needs.

- Completion of transitional planning to support the reunification of the child to the family or the child's transition to the next appropriate care resource.
- Provision of supports and opportunities for the child and youth to maintain or reconnect to family, neighbourhood and community.

As can be seen in Part 8 *Linking Assumptions to Practice* the EAPD shelter system, though well intentioned, did not carry out a number of the stated core activities required to support its intended outcome.

Internal Pressures to the Agency

Program Development

WCFS provision of emergency residential care was a response to a resource crisis. When first designed, the shelter system was based on a foster care model but as resources were needed and fewer individuals were prepared to 'foster,' the system drifted towards shift staff care. This drift was not intentional. The agency through the creation of guaranteed 12- and 24-hour shifts moved to stabilize the work force while attempting to support its service philosophy of consistent single caregiver. Due to a lack of qualified foster care providers the original model shifted from a foster care model to a quasi-foster caregiver model and finally to a permanent shift staff residential care model.

The agency was attempting to provide services while reacting to an ever-changing environment. These larger environmental pressures resulted in ongoing structural and staffing changes. The agency reorganization to a Program Model moved Human Resource support to head office. Shelter co-ordinators were left without adequate human resources supports to assist in the shift to a residential care model. The Program Model also attempted to connect Quality Assurance and Community Development programs to EAPD but given the ongoing changes to the agency structure this connection was never fully realized or supported.

In conjunction with and following the agency's reorganization, senior managers' time and attention were diverted from program development to larger systemic initiatives, leaving EAPD staff to develop the program in isolation. The program continued to grow in care capacity without adequate program evaluation and development to support that capacity. In the end the program did not develop a program model that defined its goals and objectives, resources, program activities and/or outcomes. EAPD, now required to respond to the needs of any and all children and youth requiring emergency care, operated within increasingly impermanent programmatic boundaries.

Without a program model, policies and procedures to support the program activities did not systematically develop. Originally EAPD policies and procedures "piggy-backed" onto the foster care licensing, regulations and standards. As the program's operational environment changed, moving from single caregiver to shift staff, these policies and procedures no longer fit the EAPD model.

As the program drifted from its original care model, problems quickly arose concerning administrative procedures, child management practices and roles and responsibilities and conduct of staff. EAPD managers began to address problems by developing a series of reactionary policies. These policies dictated not only child care practices but attempted to address human resource issues if the procedure employed by staff varied from the initial policy.

Reactionary policies quickly evoke staff reaction and lead to erosion of staff autonomy in carrying out their employment function. In the background but directly impacting on the development of the program was the breakdown in staff/management relations creating at times a hostile and untrusting work environment.

Licensing

WCFS also appeared to struggle in coming to understand the significance of appropriate licensing and monitoring either through the Residential Care Licensing Branch (prior to 1999) or the DFSH (after 1999). Changes to the City of Winnipeg fire code in 1998 required child care facilities (those with four or more beds) housing 0 to 10 year olds to install inter-connected fire alarms and a second means of egress. WCFS had been provided a three-year period to have their buildings brought to code in order to comply with fire code regulations. Instead WCFS made a decision to move from a four-bed model to a three-bed model to avoid the fire code regulations.

When The Child and Family Services Act was amended in 1999, it required residential care licenses for child care facilities for fewer than five children that were operated by agencies where care and supervision was provided by persons employed by the agency. Before this amendment the shelters operated without a license. The DFSH began discussions with WCFS in February 1999 to bring its facilities into compliance. This meant that the agency's previous attempts to circumvent zoning bylaws, health and fire code would now have to be addressed.

When the OCA questioned past and current managers as to why the shelters were unlicensed, no one could adequately respond. Though managers stated they were aware that the changes in the Act were coming into force they assumed that the program staff were addressing this issue with the DFSH. Potential liability and cost ramifications were never fully appreciated by agency leadership.

Staffing

Over all, the OCA found that WCFS staff interviewed were well qualified and committed to their chosen field. There were, however, a number of concerns that have been raised throughout this report about staffing of the shelters. Of most concern was the strained labor/management relationship that has created hostility, suspicion and fear among staff, co-ordinators, managers, past boards and now may possibly extend to government.

Shelter staff are isolated given their job function and location and do not feel a part of the agency service structure. The majority of shelter staff could not identify the overall service vision of WCFS and how EAPD fit into the agency's larger service vision and model. The majority of shelter staff did not possess a basic understanding of the larger role of WCFS, the mandate of the agency or the agency's organizational structure.

Supervision of shelter staff is inconsistent and does not occur across all shifts. Regular staff meetings are not routinely held and if they do not all staff can attend because of shift work. Communication between management, co-ordinators and shelter staff is fragmented. Shelter staff must rely on co-ordinators for all communication and information whether that information is case-specific or deals with overall agency activities. Staff conduct issues are not seen to be effectively dealt with by all parties (staff, co-ordinators, managers and union).

The guaranteed 12- and 24-hour shifts also impact on care. Shelter staff reported that long shifts, given the high needs of children and youth, could cause fatigue. When staff members are tired, mistakes in judgment can be made. Union officials say that the 12- and 24-hour shifts are required for children and youth that require consistency of care. There is, however, little doubt that the combination of long shifts, behaviorally challenging children and youth and the lack of effective supervisory support will impact on care.

Youth report that single staff shifts also impact on care. Single staff shifts can curtail activities. Youth also report the inappropriate matching of children residing in the shelters will also impact on care.

The guaranteed shifts and accompanying hours also impact on the agency's ability to move skilled staff to needed areas. Though staff are not guaranteed a specific work site, the agency reports that the guaranteed shift configurations prevent the movement of staff to needed areas. Staff are moved to sites where their shift configuration and hours can be met, as opposed to moving staff to meet the needs of a child or youth. As a result it has been reported that some staff may now be working with children or youth not because they have the requisite skills, personality or patience, but because the agency is required to guarantee a particular shift configuration and number of hours.

A high number of casual and contract staff are used to fill shifts. Many of them are unfamiliar with the procedures in individual shelters and this can lead to inconsistencies in the running of the shelter and the ultimate care of children and youth. Shelter staff report problems occur when contract staff are used. The majority of permanent WCFS shelter staff reported that WCFS staff and contract staff do not work well as a team. Shelter co-ordinators do not directly supervise contract staff. Children and youth report that they are not able to identify which staff are WCFS staff and which are contract staff

Training

Training of staff was a constant theme raised throughout this review. Generally it appears the WCFS shelter system lacks a comprehensive staff development strategy that can integrate training, supervision and regular performance appraisals.

The lack of effective training has direct impact on the care of children and youth. When dealing with behaviourally challenging children and youth it has been reported that staff will often enter into power struggles which can escalate situations. It has been reported that staff in such situations will "get too hands on too quickly." Staff will seek the assistance of police when having difficulty with behaviourally challenging youth. However 14 per cent of requests for police assistance are in response to a "suicidal youth". The YECSS system, a community based crisis response program designed to deal with such issues appears to be under utilized. However shelter staff reported difficulties in relating to the YECSS system.

The agency has never completed a review of its present staff and their level of skill and expertise. Nor have they systematically offered additional training for dealing with challenging children and youth. Certainly there are skills common to all levels of the child care profession. But additional and specialized skills are often required to work with sub populations of children, such as the younger child, the physically challenged child, the child with pervasive developmental delays, the victimized child or the child who is diagnosed as suffering from Fetal Alcohol Syndrome. The agency does not expect that each child placed will have similar needs but the structure of EAPD assumes that all shelter staff as child care workers possess an equivalent set of skills to deal with all children and youth. This simply is not possible.

Shelter co-ordinators have limited opportunity for training in supervisory skills. Co-ordinators have important role in supporting staff in providing care to children and acting as a liaison with other agency staff and community collaterals. They too require additional training and support to carry out this very important role.

Previously the DFSH offered WCFS to participate in Competency Based Training for childcare supervisors and staff. WCFS did not partake in this training, due to reported financial limitations. The agency should endeavor to do so. CBT training has the additional benefit of assessing current staff training needs and therefore allows the agency to assess the current level of skills among their staff group, including shelter co-ordinators.

More importantly the children and youth are entitled to the highest quality of care. Qualified, trained and well-supervised staff can ensure that quality of care. Any future system must develop and institutionalize a professional training capacity that uses professional and community resources to meet training and staff development needs. Correspondingly, our CFS system must be provided the financial resources to address training and staff development needs.

Quality Assurance

Throughout the review the OCA requested program evaluation, needs assessments or costs analysis with respect to the EAPD system. Beyond the Prairie Research Report (1997), that spoke briefly to aspects of emergency care, no formal evaluations had been completed. When the agency re-organized into a Program Management Model, the Quality Assurance program was to take the lead role for "service reviews, program research and evaluation, policy analysis, co-ordination or response to external reviews, and agency risk management" (WCFS 1999:24).

This program was used in determining the number of emergency beds needed and the location of shelters. This was done in conjunction with the EAPD now under the umbrella of the Resources in Support of Services Program. It was hoped that these programs and the agency's community development program would assist the development of EAPD. The agency developed an over-all Action Plan to address a number of issues including resource development. By 2000, as the agency moved to address other initiatives, the Action Plan ceased to be operational.

The connection between Quality Assurance and EAPD was never fully realized. Had it been, the agency could have better developed and evaluated the EAPD program. Consequently the EAPD program developed without an evaluation of cost, impact, effectiveness or outcome (intended or unintended) of the program. This is most evident in the program's inability to accurately describe its service population - the children and youth.

Management Information System

The OCA found that the agency never clearly reviewed the population served by the shelter system. Shelter resources were developed to "fill the gap" when placement was needed. There was no analysis of the population and their corresponding needs (problem identification). The agency and ultimately the DFSH relied too heavily on descriptive case-specific information, excluding longer-term issues and the development of appropriate alternatives. The agency quickly developed tunnel vision regarding the population the shelters were serving and in its attempts to create alternatives.

The agency operates multiple data base systems. The agency's case management information system (CFSIS) is not effectively utilized to gather information to adequately project needs. Without knowing the problem or the primary service population and their needs, the agency could never further prove its case to its funders or develop a program to address the needs.

Financial Development and Control

As the EAPD program developed, the costs associated with shelter care continued to rise. Agency managers attributed the increased costs to the increased needs of children and youth requiring care and the costs associated with guaranteed shift hours and configurations.

During our review, the OCA heard allegations that the shelters were not adequately funded. Each shelter is provided funds on a semi-monthly basis to purchase food, household items and provide recreational opportunities for children and youth based on their assigned, but not necessarily filled, bed spaces.

During our review allegations were raised by a minority of staff that items would go missing (primarily food) from the shelters. The OCA, following consultation with senior officials from the DFSH, requested the assistance of Internal Audit and Consulting Services. Overall it was found that "adequate procedures" had "been established to ensure a satisfactory level of control over expenditures in the shelter system and to provide reasonable assurance that expenditures are being made as intended".

Though the fundamental controls were found to be adequate, there were a number of issues regarding the implementation of procedures, primarily the shelter system lacks a formal procedure manual to guide co-ordinators and staff in the management of the allotments or disbursements. The ability to budget the allotments varied among staff. The use of contract staff in some of the shelters makes it difficult for some shelters to fully implement the procedures. The degree of monitoring procedure implementation, a responsibility of the shelter co-ordinators, varied among co-ordinators.

Further and fundamental to the daily operation of the shelters, and the care of children and youth, was the determination of the allotments provided to the shelters. The determination of the allotment to the shelter was not based on age of child but on bed space. Establishing rates for care premised on bed space is contrary to other funding models in foster care, residential care and even within the provincial income assistance. Disparity existed in the shelters when funding based on bed space is expected to provide for more than just the residents. The current funding allotment for food is expected to cover the cost of feeding both staff and residents. But the rates are not adjusted to cover additional staff when they are required. The current allotment method forces some shelters to manage more frugally than others. "Shelter staff occasionally cope with tight budgets by temporarily 'lending' their own funds to meet the needs until the next allotment cheque arrives or resorting to no-cost recreation or cheaper food."

When WCFS staff (line to middle management) were asked about the budgetary process, we were told that to their knowledge there was not a process in place. Executive managers described a process that took into account consideration of actual expenditures, days in care, the average cost of a day care and consideration of new program initiatives. However, the 2002 to 2003 budget for the shelters "was established at a level 41.7 per cent lower than the prior year's actual expenditures. The estimated number of days in care, which is the primary basis for the budget, was 35.5 per cent lower that the prior years' actuals. The rationale for these reductions was not readily evident." This process contributed to the agency going over budget.

The review found no valid process to determine the monthly allotments or realistic EAPD budget; at times budgeting was based on unrealistic assumptions (reduction of days in care) leaving the agency with little ability to effectively analyze or reasonably project costs.

The Quality of Care

Basic Care

Overall the OCA found that the basic care provided to children and youth was adequate. Children and youth reported that routines were established in the shelters, they received adequate nourishment and were involved in daily activities. Personal hygiene items were provided. Some issues pertaining to inadequate clothing were brought forward by youth that reported difficulties in contacting their social worker that could authorize purchase of clothing.

Home-Like Environment

The OCA undertook site inspection of 47 shelters. The goal of the program was to provide a safe and nurturing home-like environment in the community but this goal was not consistently met. Physical location was a significant factor weighing upon quality of care for children and youth. Many shelters were in neighbourhoods that could present potential safety and risk factors to children. Many were in areas where social concerns were evident. Of particular concern are the shelters located within WPS District 1. This area contains 24 per cent of the shelters. Of these shelters 90 per cent were rated as least desirable due to their close proximity and exposure to observable criminal and anti-social activity (drug trade, adult sex trade) gang activity, abandoned homes, and high incidence of reported crime. It was the collective opinion of children, youth and staff that these areas are high risk. Children said they did not feel safe outside some of the shelters.

In addition to safety issues, many youth expressed concern that they were placed in homes far away from their families or the communities to which they were connected.

Admissions, Discharges and Assessments

The *Child Care Facilities Licensing Manual* and the EAPD Home Manual provide a guide for specific processes for case planning in the shelter system. This should include information admission to and discharge from the facility. The Home Manual provided a checklist form for each child. These checklists are to assist staff in assuring appropriate documentation concerning a child is received, or forwarded, and all necessary appointments have been scheduled. The EAPD shelter system also is to complete basic functional assessments while the child resides in the shelters. These assessments are to assist in planning for the child.

The most pertinent information that would assist shelter staff in providing care is located within the admission forms. Shelter staff complained that information about the child is either not routinely provided or not provided to them in a timely manner by placing workers. At times placing social workers are uncertain as to what information they can share with shelter staff, citing confidentiality as a reason. Overall assessments are not completed, nor are staff provided any training to assist them in completing such assessments. Shelter staff reported discharge planning as being uncoordinated with no formal written procedure.

Generally children and youth describe their admission to the shelters with feelings of uncertainty, fear and apathy.

School Attendance

School attendance for those in the shelters is inconsistent at best. Shelter staff reported that almost one third of the children do not attend school after admission to the shelters. Issues such as transportation, enrolment in the new school, proximity of the shelter to the new school and general lack of communication with school personnel had been identified as barriers to school attendance.

Of the children and youth interviewed 82 per cent reported attending school before admission to the shelters; only 66 per cent reported attending school after their admission.

Programming

For children and youth that do not attend school or day programming very little is available in terms of activity inside the shelter system. The majority of the shelter staff could not accurately identify programs offered to assist children and more specifically youth when they are placed. Programming appears to mean the provision of recreational opportunities. However, there was inconsistency as to what would constitute a recreational program. Some shelter staff described programming as watching TV, playing video games, and going shopping. Other described recreational activities as including physical activities or going for walks and going to the 'Y'. Programming was, however, very much dependent on the availability of money. If the shelter experienced problems, money for recreation would be used on other items such as food.

The majority of children and youth cited watching movies or playing video games as the most common form of recreational programming inside the shelters.

Behaviour Management

Shelter staff reports that they manage children and youth behaviours primarily through the restriction of privileges, verbal redirection and the use of time outs. Of concern is that staff are unable to consistently describe the EAPD policies with respect to behavioural management beyond the use of Non Violent Crisis Intervention or restraint as a last resort to manage aggressive behaviour. Yet 20 per cent of staff report using physical restraints on children ages 6 to 12. Sixty-eight per cent of staff advised that they have used physical restraint at some point in their career in EAPD. Twenty-two percent of youth report being physically restrained.

DFSH staff and collaterals reported that they believe shelter staff enter into power struggles and get too hands on too quickly. Concerns were raised about inappropriate restraint methods, which could lead to injury.

Incidents such as the use of physical restraint are to be documented and reported. Overall the OCA found inconsistent reporting of incidents to the agency and to the DFSH. Even if incident reports were properly documented and reported, neither the agency nor the DFSH routinely track these incidents. Any probative value to the incident reporting is lost to our system.

What the Children and Youth Say

Generally children and youth reported positive relationships with their WCFS social workers. Overall, children and youth identified an adult (social worker or shelter co-ordinators) that they could confide in if they had a problem in the shelter. But only 33 per cent were able to identify a shelter staff who they view as their primary worker; a shelter staff person who would help them when they had problems. Fifty percent of the children interviewed report that shelter staff "yell" at them; 22 per cent of youth report that staff "swear at them" and 33 per cent of youth reported feeling "put down" or humiliated by shelter staff. Children and youth did report knowing when shelter staff have conflict with other staff inside the shelters.

The majority of children and youth reported that they are unable to maintain contact with their peers while in the shelters. Though the majority of children and youth report having family contact while they are in care, only seven per cent report being allowed to have family contact in the shelters. However, 48 per cent of youth report having unsanctioned contact with family while residing in the shelters.

Though children and youth generally felt safe inside the shelters, they reported not feeling safe in the neighbourhood. They also reported that at times other children and youth placed in the shelters could impact on their safety. Though a majority (58 per cent) stated they generally like the other children and youth they also reported that a wide age difference and a lack of commonalties were the two primary factors which impact on the shelter environment. Primary school aged children complained about being placed with infants. Youth complained that other residents stole their property or would engage in verbally, or at times physically, aggressive behaviors. Children and youth report appropriate matching and mixing of residents to be a key determinant in settling into a shelter placement.

The majority of children and youth reported wishing they were some place else other than the shelters. Forty-one per cent of youth reported running away from the shelters, as did 33 per cent of the children interviewed. The majority of children and youth desired to return home following their discharge from the shelter system.

Our Emerging System

It has become apparent that there is a need for an emergency care system specifically serving the City of Winnipeg. This system must be an integral component within the Provincial Care Continuum, regardless of the population served. It is anticipated that any system of emergency care will evolve as it responds to the needs and pressures placed upon it.

The system must operate within programmatic boundaries and guidelines that clearly outline goals, objectives, anticipated outcomes, and policies and procedures. It must be continually evaluated, not only to ensure that it is achieving its goals, but also to recognize progress that may not have been anticipated. The use of a Quality Assurance function is central to the measurement of this program's success, is integral to accurately projecting the programs funding needs, and is vital to determining whether the program meets the needs of the children it serves. Quality Assurance should always seek to obtain the input of these children.

> "It was a very short time ago in our history that residential schools were considered the right thing to do for children of First Nations. Now we understand that this was a tragic mistake, and a mistake that could have been avoided if someone had taken the time to listen to children. Today, the debates continue around policies for foster families and adoption, the best way to deal with young offenders, and the best treatments for all kinds of behavioural and mental health problems. What we believe about many of these issues today may not be what we believe in ten years. However, what we should always believe is that it is right to listen to the children involved, and when they cannot speak for themselves, to try and do everything possible to see the situation through their eyes. This applies to decisions made about individual children, and to decisions made about the system that serves them."

(A review of the Office of the Children's Advocate, Province of Alberta. Chan Durrant Ltd., 2000 p.3-4.)

PART 10: RECOMMENDATIONS

Any recommendations made as a result of the review of the EAPD shelter system must be made with one primary and over-riding thought in mind. Every day in the City of Winnipeg there are on average 120 children and youth that require some form of emergency care. Social workers who are charged with the overwhelming responsibility to protect children and youth must have access to placement resources.

The recommendations, made in this report, will address the system-wide policy implications and the structure needed to support what clearly has become a placement reality. These recommendations will also demonstrate what is needed to improve the emergency care system to ensure quality of care and best practice for both short and long term care.

These recommendations recognize that WCFS is now a branch of the DFSH. Any recommendation concerning the DFSH speaks to the larger entity, and not WCFS as a component, unless otherwise indicated by the term "agency." As well, the OCA recognizes that our CFS system is changing and that there are now Four Authorities who in the near future will be providing care to the children and youth now served by the agency. Though the Four Authorities were in no way responsible for the EAPD system they will develop a new system in partnership with the DFSH. The input of the Four Authorities is needed to ensure that any emergency care system developed meets the needs.

Clearly there are no quick fix solutions and the challenges faced in improving the system are many. Those challenges must now be viewed as an opportunity to improve the lives of children and youth that we have the responsibility of serving.

SECTION ONE: THE LARGER SYSTEM

1. 1: Policy Implications

The EAPD program was to provide short term emergency care to children and youth. The vision was that children and youth entering the CFS system due to family crisis could be safely housed while attempts were made to stabilize the family and allow for the safe return of the child or youth. Emergency care was to avoid multiple placements by allowing a child to remain for a specific period of time for an assessment based on their individual needs and issues. This assessment would assist social workers in developing appropriate care plans. An emergency care system should have the capacity to support the efforts of social workers in reunifying children with their families where at all possible. Should reunification not be possible then the child assessment completed within the emergency care system should assist in developing the appropriate care plan.

The EAPD system appears, however, to be primarily supporting the CFS care system. It appears that the majority of children and youth are entering into the EAPD system as a result of foster care breakdown and a smaller percentage are from the breakdown of residential care placements. The social policies and funding implications are clear as this situation implies that our child welfare system is not able to support the care plans of children and youth inside its own care system. This concept is potentially difficult for many in the general public to grasp and fully understand; after all children and youth in the shelter system are in care. It can, however be equated to the building of an emergency ward that serves primarily patients already in the hospital.

Recommendation:

√ ***The DFSH in conjunction with the Four Authorities review the information and demographic data provided in this report, and fully analyze the legislative (regulatory), the policy (service and fiscal) and resource (supportive, supplemental and substitute care) planning implications as it relates to the evolving child and family services system.***

1.2: The Provincial Vision for Out-of-home Placement Options

A continuum of care assumes that there is an array of services available to children and youth with a clearly delineated entry and exit point. A true continuum would dictate a progression of services, if required, based on the assessed need of a child or youth and their families and the ability of the service to meet those needs. A true care continuum should provide preventative in-home supports as well as out-of-home care or what is known as substitutional care.

Currently the provincial care continuum as seen in Part 2 is not reflective of a true continuum. It focuses on care provided outside the familial home when services are needed to address family crisis. It does not include preventative services to assist families in caring for children in order to avoid out-of-home placement. It provides no clear entry or exit point.

Recommendation:

√ *The provincial continuum of care be re-developed by the DFSH and the Four Authorities to reflect a true continuum and include preventative, supportive services, supplementary services and substitutional care services. Care of children and youth can be provided by the CFS system and or by the families of the children and youth, and as such, should include culturally-appropriate resources that will support and augment the care of a child. Accessibility of services under the continuum of care should not be based solely on a child's care status, and should minimally include:*

Supportive and Supplementary Services:

- *Preventive services to support children and their families in the community.*
- *Supplementary services to support children in their families in the community.*
- *Family Reunification services to support children returning to their families from care.*
- *Therapeutic Daycare and Emergency and Respite Daycare*

Out-of-Home Care Resources:

- *Substitutional care services ranging from, kinship care, adoptive care, foster care, including therapeutic foster care and family based care settings for siblings.*
- *Residential care including care settings specializing in variety of high needs service areas including FAS/FAE, drug/alcohol/solvent abuse programs, behavioural challenging child and youth. Bail supervision homes for youth involved with the CFS system leaving correctional facilities on bail but unable to return to their home or previous care setting.*
- *Shelters (Emergency and Street shelters).*
- *Facilities (group or individual) for adolescent parents and their children*
- *Respite care (for parents, kinship, foster, adoptive homes).*
- *Independent living resources (youth ages 16-21).*
- *Specialized Care settings (family and group) appropriate for defined subgroups such as English as a second language; physically handicapped, visually impaired and hearing-impaired children and youth.*

1.3: Coordinating Structure

The question often raised is how substitute, particularly residential care, resources are developed for children and youth. The claim is that there are not adequate resources to meet the needs. We have heard that children and youth are inappropriately placed in facilities not programmed or capable of meeting their needs. We have heard consistently from agency staff that there are not adequate resources available for multiple and high needs children and youth.

1. 3(a): Out-of-Home Placement Resource Co-ordination

Resource development is often left to individual agencies, mandated and not mandated, to develop resources based on needs of a specific at risk population that come to their attention. As stated by DFSH officials, resources are often built to accommodate crisis. Generally there appears to be no overall vision and co-ordination of resource development specific to residential care for children and youth. System co-ordination of resources development is required.

Our CFS system needs to develop the capacity for community resource development for out-of-home care for children and youth in a systemic and planned fashion. Doing so will allow our system to:

- Identify current and projected resources needed by children, youth and families.
- Communicate and demonstrate to the community and policy makers that those resources are needed.
- Obtain appropriate level of financial support for those services.
- Develop a province-wide service capacity to meet the identified and projected needs within our communities.
- Monitor the services to assure that they effectively meet the needs of children and youth.

Recommendation:

√ ***It is recommended that the DFSH develop, in conjunction with the Four Authorities, a Community Resource Development Office (CRDO) to be housed in the DFSH.***

The CRDO will need to determine and identify the current resources existing in our communities. A review of all open Child in Care cases is required to identify initial service needs and resource requirements and to assist in determining placement resources required to meet the needs within the current caseloads. This review can be used to adequately project future need based on the current population.

Recommendation:

√ ***It is further recommended that the CRDO complete a province-wide community needs assessment of the service providers to find out what resource and service needs are immediately required.***

The ongoing focus of the CRDO should be to work with CFS system and community stakeholders to:

- ***Develop residential care resources across the province, including emergency care facilities and treatment centres across departments and jurisdictions.***
- ***Assist in the development of in-home support and community services resources to support children and youth in the community.***

- ***Provide linkages with and between government departments and other public and private agencies and the Four Authorities to allow for cross-jurisdictional planning of resources.***
- ***Assist in the development of neighbourhood-based services.***

1. 3(b): Standardized Resource Classification

To determine whether out-of-home placements are meeting the needs of children and youth and the ability of their caregivers to meet them requires a system to evaluate the quality of care in similar types of out-of-home placement resources. A coordinated and standardized system should assess a care resource in areas of: target population served, level of skill of care provider, intensity of supervision and support to child, level of structure and type of programming offered, treatment and therapeutic services provided. The standardized classification system would assist in matching the specific needs of a child (medical, psychological, physical and intellectual challenges, cultural and linguistic needs) entering out-of-home care with the most appropriate setting.

Recommendation:

√ ***The DFSH through the CDRO develop a standardized classification system for all out-of-home placement resources within the CFS system to evaluate type and quality of care provided amongst similar homes and facilities. The classification system would assist in assessing a child's service needs in relation to the current available resources, while simultaneously identifying gaps that exist.***

1. 3 (c) Provincial Placement Desk

Currently all admissions to residential care must be vetted through a central Provincial Placement Desk. Based on information provided by a CFS agency and the current resources available, the Desk matches child to care facility. This Desk is in Winnipeg and has no visible presence in rural, northern and First Nations communities. This Desk does not include representation of the all CFS agencies, First Nations CFS agencies, the regions or the community.

WCFS workers also stated to the OCA that they rarely present to the Desk. Others stated that they do not believe that their assessments are given full consideration at the Desk. In other cases, social workers from northern and rural areas also spoke of either not understanding the Placement Desk process and of not being able to secure residential care resources for their children and youth. Generally social workers spoke of the long waiting lists in residential care, the lack of communication from the Desk, the feeling that they have little if any control over where the child is placed. WCFS staff firmly believed that many of the children and youth in the shelters are returning from residential care breakdowns.

Recommendations:

√ ***The DFSH in conjunction with the Four Authorities redesign the Provincial Placement Desk. A single Desk, managed and co-ordinated through the DFSH should be created. The Desk should incorporate a multi-disciplinary membership, inclusive of the,***

- ***Four Authorities***
- ***DFSH***
- ***CFS agency (rotating) membership***
- ***Child Mental Health***
- ***Residential care (rotating) membership.***
- ***Youth Justice***
- ***Children's Special Services***
- ***Education***
- ***Community***

The Desk should allow for additional case-specific members whose expertise can assist in the overall planning for a child to be brought in as needed.

- √ ***Social work staff who are applying for a residential care admission should whenever possible present in person to the desk as well as provide written assessment material. Whenever possible the Desk should travel to rural and northern areas. If this in not economically feasible then all efforts should be made to ensure that agencies are provided the funds to allow their social work staff to travel to make presentation to the Desk or present to the Desk through alternative communication technology (i.e. telephone conference, video conference).***

- √ ***All admissions and discharges from residential care should be under the authority of the Desk. As part of their co-ordinating roles the DFSH should immediately begin tracking of all residential care breakdowns. Such information should be shared annually with the Four Authorities as well as with the residential care system.***

Throughout the interviews with WCFS staff it became apparent that they are unaware of the available bed openings in residential care. Though social work staff do not have the authority to place a child in residential care directly, they still need to know when beds are opened and in what facilities. This information should be available to all social workers in Manitoba.

Recommendation:

- √ ***The DFSH post, through a secure site, accessible only to CFS agency staff, all residential care bed openings. This site needs to be kept up to date and include a description of the residential care facility and the program offered. Such information will assist line staff in better planning for their children and youth.***

1. 3(d)Provincial Abuse Investigator (PAI)

The role of the PAI is important and much needed. The PAI's reports are, however, limited in that they only focus on individual allegations and cannot be used to determine patterns or themes emerging in a specific shelter. The PAI role is primarily to determine if abuse occurred as defined under the CFS, a definition that is limited to an act or omission which causes a physical "injury" to a child. Recommendations are restricted and cannot include any recommendations that would affect an individual's employment status.

In 1992, P. Colleen Suche completed the Independent Review of Reporting Procedures in Children's Residential Care Facilities. This review called for a Central Team to be established to investigate allegations of abuse in residential care and be assigned to the Office of the Children's Advocate. The OCA does not believe that this team should be assigned to the OCA but would recommend:

Recommendations:

√ ***The DFSH create one additional position to investigate allegations of child maltreatment in all forms of residential care licensed by the Province of Manitoba. These positions remain centralized to the DFSH given that it is the department that is the licensing authority.***

√ ***The PAI should not be bound by the definition of abuse but be allowed to investigate all concerns related to questionable child management practices and provide recommendations for corrective action.***

√ ***The PAI should be allowed to make a variety of recommendations, including a person's employee status, as it relates to conclusions reached by the investigator of the appropriateness of a staff person's individual behaviour and job performance.***

√ ***The PAI be required to investigate all allegations against all staff, either permanent or purchased-services staff, providing care in the shelter system.***

√ ***The Agency institute a mechanism to respond to all future PAI reports, outlining corrective actions with stipulated time lines. Further all PAI reports are copied to all required management personnel, including the Human Resource Director in WCFS for information and direction.***

√ ***The DFSH, as the Licensing Authority, institute a mechanism to track all of the PAI's reports to ensure compliance with recommendations.***

1.4: Integrated Services Planning

WCFS told the OCA that many of the children and youth that entered and then stayed in the shelter system were high-needs children and youth. Many of these children and youth receive services from such government branches and departments as Health, Child Mental Health, Education, Youth Corrections, Children's Special Services. However, once a child/youth enters into the CFS system it is often the CFS agency that is alone in planning for children without the necessary supports and resources from other systems. Many of these children face barriers in accessing the required services in other systems. These children can no longer afford planning which occurs in isolation of the other systems.

Recommendation:

√ ***That the DFSH examine the feasibility of creating an Integrated Departmental Services Committee (similar to that of the Inter-Ministerial Provincial Advisory Committee – IMPAC, in Ontario) that would address barriers created through policy that prohibit continuity of planning for children across government service sectors.***

1.5: Collateral Service Systems

Recommendations:

- √ *The DFSH review the information provided by the OCA with respect to the YECSS system. The DFSH then enters into discussion with the Agency and YECSS to determine if the shelter system is adequately utilizing the YECSS program. Further these discussions continue as the new shelter system is developed to ensure that any new system has ease of access to YECSS resources as required.*
- √ *The DFSH review the information provided in this report as to the shelter's use of Winnipeg Police Service. The DFSH and the Agency then enter into discussion with the WPS to formulate policies and procedures formalizing police response to both the current and future shelter system.*

SECTION TWO: THE CURRENT EAPD SYSTEM

2.1: Cost of Care

The OCA is aware that the resources of WCFS will be distributed as the AJI-CWI process unfolds. To distribute the resources of the shelter system to the Four Authorities cannot, in the opinion of the OCA, occur until a budgetary process has been implemented and a realistic budget created based upon actual cost, days in care and projected needs bound within programmatic structure. To do so now based on the information provided by WCFS would simply perpetuate existing financial problems.

Recommendations:

√ ***The DFSH immediately request Internal Audit (IA) to complete a financial management practice review of WCFS, now a branch of the DFSH. From this starting point, the DFSH, in consultation with IA, develop a realistic budgetary process that will take into consideration actual costs, current and expected needs of the agency's service system.***

√ ***The DFSH in consultation with IA analyzes current shelter system expenditures and itemizes and documents each cost element.***

√ ***Following establishment of the budgetary process, the DFSH in conjunction with WCFS, identify the operational issues of emergency care service delivery and develop a realistic funding formula for the current shelter system.***

√ ***Following the resolution of the budgetary process and the establishment of a realistic budget, the DFSH, in conjunction with the Four Authorities, identify the operational issues and create a program model for emergency residential care.***

√ ***That the DFSH adopt control and responsibility of the current shelter system until the aforementioned recommendations of cost of care have been completed***

2.2: Proposed Amendments to the Current Shelter System

2.2 (a) Program Development

√ ***The Agency obtains the assistance of independent residential care expert(s) to create and document a program model for their current shelter program.***

√ ***The Agency develops a policies and procedures manual reflective of Child Care Facilities Licensing standards, regulations and Child Welfare League of America's best practice standards.***

√ ***The Agency develops the capacity to track internal incident reports and ensure that all required reports are forwarded to the DFSH.***

√ ***The DFSH and Agency examine the PAI reports and the incident reports to determine if patterns exist that contribute to poor child management practices, and take corrective action.***

√ ***The Agency, in conjunction with the DFSH, develops the position of Educational Specialist to act as a liaison between the educational system and the emergency care program. The Educational Specialist should have a background in education and policy administration in order to assist with transitioning children In schools,*** *to support children during this transition, and to assist with the development of educational planning and funding applications where necessary.*

√ *The Agency, in conjunction with the DFSH, develops the position of Health Specialist to act as liaison between the emergency care program and the public and mental health system. This position would be in addition to their current health care coordinator. The Health Specialist should have a background in public health in order to support shelter staff in providing health intervention to children with specific medical care needs. The Health Specialist should also be responsible for the provision of training in health prevention for issues such as communicable diseases.*

2.2 (b): Co-ordination and Supervision

√ *The Agency should assign a position specifically responsible for co-ordination and operation of the shelter program. One possible way of achieving this is to remove from the current project manager all responsibility for the implementation of the consolidation plan and reassign to this position the responsibility for co-ordination and operation. The DFSH continue to support the program through the continued provision of a seconded staff person who should work under the project manager to co-ordinate the shelter program.*

√ *The Agency ensure supervisory responsibility of all shelter coordinators be designated to the newly created position responsible for the coordination of the shelter program.*

Through this designated position:

√ *The Agency ensures that all shelter staff has access to supervisory staff across all shifts, as has been implemented within the agency after-hours unit.*

√ *The Agency ensures that the shelter coordinators directly supervise all purchased service staff.*

√ *The Agency ensures all shelters have monthly team meetings.*

√ *The Agency undertakes regular site inspections and ensures all shelters meet licensing requirements.*

√ *The Agency ensures that all shelter staff has on-site access to the agency's internal computer information communication system. This would not include access to the case files but access to email and general agency information for agency staff.*

2.2 (c): Training

√ *The Agency ensures that all their permanent/casual shelter staff receive CBT for childcare workers employed in the shelter system.*

√ *Prior to the Agency employing purchased-service agencies to provide childcare in the EAPD system the Agency ensure that all purchased-service staff have successfully completed CBT training. Such training should be made available to these outside agencies, however the costs of the training should be absorbed by the purchased-service agency.*

- √ *The Agency ensures that all shelter co-ordinators and staff, including purchased-service staff, are certified in NCVI. Further all staff should be re-certified yearly.*
- √ *The Agency co-ordinate the use of purchased-service staff through one central management position until the use of purchased services can be phased out entirely.*

2.2 (d): Human Resource Administration

- √ *The Agency expands their human resource program to support the shelter system. All personnel files should be housed in the HR program and be maintained in manner consistent with current departmental standard.*
- √ *The Agency, in conjunction with the DFSH, develops administrative HR standards, policies and procedures consistent with departmental standards.*
- √ *All shelter coordinators be provided with regular HR training about the current collective agreement and performance evaluations.*
- √ *All shelter coordinators and permanent/casual shelter staff receive yearly performance evaluations.*

SECTION THREE:
THE FUTURE EMERGENCY CARE PROGRAM

Emergency Care for children and youth is an unfortunate reality of our CFS system. Its licensing, operation and programming require development to meet the needs of children and youth. It is a system that needs to be at the front door of the CFS system allowing intake workers ease of access. It is a system that should not be able to turn away children and youth. But it is a system requiring co-ordination, realistic funding, resources and development.

3.1: Governance

Until the financial issues of the current shelter system have been addressed it has been recommended that the DFSH hold responsibility for the shelter system. The problem emerging is that the DFSH also holds the oversight responsibility. This situation cannot be supported long term.

Recommendation:

√ ***The co-ordination and development of any future shelter system serving primarily the City of Winnipeg should rest outside the mandated child and family service system. Governance over the shelter system should come from a non-mandated child welfare agency or authority. The system needs a buffer between those who are placing children and youth, those who are providing care and those responsible for licensing and regulating care. It is a clear conflict for the regulatory bodies and or authorities to license, regulate and provide care. The choice of which system should be brought into overseeing the development of the shelter system in partnership with the DFSH and the Four Authorities is a decision better made as the AJI-CWI process unfolds.***

3.2: Shelter Standards

The creation of any shelter should be at minimum based on the assumptions of shelter care as outlined in the CWLA standards. Utilizing these standards would assist in providing the best possible care for children and youth to grow, to develop and to maximize their potential while in out-of-home care.

Recommendations:

√ ***The DFSH will develop care standards and licensing regulations specifically for emergency shelter care that reflect the CWLA assumptions including:***

- ***No child or youth shall remain in a shelter setting for longer than 30 days. This time line is renewable for one additional 30-day period to allow for continued assessments. No child or youth shall remain longer than 60 days.***
- ***All shelters shall provide structured programming within a given program outline (ie: recreational, life-skills, cultural programming).***

- ***Functional assessments shall be completed which can be used to assist in care planning and transition to the new placements.***
- ***Each shelter will be age appropriate and have a routine and set rules that will promote healthy life and development***
- ***Provision of competent and regular emergency medical/dental care with attention provided to special medical needs.***
- ***Employment of qualified and competent staff with at least a two-year child care diploma with experience in behaviour management, crisis intervention and prevention, counseling, and recreation and supervision of children/youth.***

Currently the DFSH has only one staff person to review and license all residential care. This is inadequate, as this one position must not only license but also complete annual reviews of all residential care programs in the province.

√ ***The DFSH add one additional position to the licensing program and further ensure annual reviews are completed of all residential care programs in Manitoba.***

√ ***The DFSH licensing program review all requests for variances in the shelter program, and complete a site inspection and review of the needs of each child in the shelter prior to issuing the variance. Further the DFSH should give consideration to expanding this recommendation to include all residential care.***

√ ***The DFSH require that any variance issued should be posted in the facility.***

3.3: Staff Competencies

Much has been said in this review about the lack of training provided to shelter staff and shelter coordinators. Training is clearly needed. Currently Manitoba offers Competency Based Training (CBT) for residential child care staff and supervisors. Competency-based training is "designing, delivering, and evaluating training that ties worker performance to the goals of the organization and its deployment of resources" (Walsh 1994:107). CBT delineates between "the requisite knowledge, skills, and attitudes for a particular area of practice" and then develops "curriculum content and approaches"(Walsh 1994: 107).

CBT would first require that the agency assess the training needs of their staff. As stated by Walsh (1994)

> "Friction caused by drifting expectation and needs is minimized when there is agreement about training outcomes and these are jointly evaluated. Moreover the learning needs for the individual staff members can be better planned for using a competency-based approach to design both social work curricula and child welfare in-service training".

Recommendations:

√ ***Successful completion of Competency Based Training become part of the licensing process of an emergency shelter with respect to staffing qualifications as is First Aid and NCVI training.***

√ ***DFSH build into the funding formula of the EAPD system, current and future, training dollars to ensure agencies can provide CBT training to their staff.***

- √ ***The DFSH review the CBT in order to ascertain if training can be provided through a combination of in class and computer assisted training. Individual computer assisted training can offset the cost of shift coverage and will be less disruptive to the shelter system***

3.4: Group Care Model

The CFS system will need time to plan and create a new alternative home-like shelter setting for the populations they serve. Any new program will require a detailed program model that outlines goals, objectives, and anticipated outcomes. The program will also require the development of a policy and procedures manual that guides every aspect of the program from administration to service delivery. Recognizing that program development takes effort and time, it is recommended that the following recommendations be phased in over a two-year period.

3.4(a): Placement of Children

Recommendations:

- √ ***It is recommended that no children ages 0 to 7 years of age are placed in any emergency group care facility.***
- √ ***All other group care shelter facilities shall be licensed based upon gender specific age categories,***
    - ***Primary School age (8-10) up to a maximum bed capacity of four beds.***
    - ***Pre-adolescents (11 to 13) up to a maximum bed capacity of four beds.***
    - ***Mid adolescent (14 to 16) up to a maximum bed capacity of six beds.***
    - ***Late adolescent (16+) up to a maximum bed capacity of six beds.***
- √ ***Youth varying in ages and of opposite gender shall not be placed together. Under no circumstances shall licensing variance be provided which mixes the age groups and gender.***

3.4 (b): Exceptions

Recommendations:

Children ages 0-7 will not be placed in group care setting except in those instances where,

- √ ***The child has exceptional needs documented by a specialized evaluation, and there is evidence that the facility can met those needs.***
- √ ***Placement of a child 0 to 7 would avoid the separation of a sibling group if the sibling group were placed together in one shelter. The CEO of a CFS agency and the Director of the organization in charge of the group shelter must approve such exceptions.***
- √ ***Shelters designed to house children in these in exceptional circumstances shall be licensed to a maximum of six beds.***

3.4 (c): Staff- Child Ratios

As children ages 0 to 7 are removed from the shelter care (with the exception of those that fall under the exception category), and a clear delineation has been made for the 8 to 18 age group, the child to staff ratios and subsequent staff hours should be changed.

Recommendations:

√ ***All shelters shall operate under an eight to a maximum of 10-hour shift configuration.***

√ ***Child to staff ratio shall be one staff member for every two children/youth throughout all shifts. Particular attention needs to be paid to bringing on additional staff or scheduling of staff during times when incidents would most likely occur.***

3.4 (d): Special Needs Children

Shelters cannot be all things to all children. Instead of fitting the child into the program the program should fit the needs of the child. Throughout this review, the OCA was made aware of the lack of available resources for children with specialized needs. Shelters were designed to meet the basic needs and accommodate these children, but were staffed by workers who did not have adequate specialized training to assist them in reaching their maximum potential. Every child, regardless of its level of care, has the right to achieve its maximum potential. This requires the development of specialized services within emergency care for these children.

Recommendations:

√ ***Shelter settings up to six beds shall be designed to accommodate sibling groups.***

√ ***Shelters of up to four beds shall be designed to accommodate the physically challenged children and youth. No child under age 7 shall be placed in these shelters unless it is to accommodate a sibling group. These shelters shall be wheelchair accessible and designed to accommodate the special needs of physically challenged children and youth.***

√ ***The DFSH enter into discussion with those organizations now providing shelter services and community based programs with respect to expanding street shelter programs (bed space availability) and out-reach program to assist youth.***

√ ***Until the CRDO is fully operational, the DFSH and Manitoba Justice enter into discussion to develop emergency care shelters for youth leaving Youth Custody Facilities who are unable to return home or secure alternative care.***

√ ***Until the CRDO is fully operational, the DFSH enter into discussion with the Department of Health (Child Mental Health) to develop emergency care services for youth leaving child metal health facilities who are unable to return home or secure alternative care.***

√ ***Single or two-bed shelters may from time to time be required due to the high or special needs of a child or youth. The system still requires the ability to create this alternative.***

3.5: Multidisciplinary Team Planning

Single bed shelters have become the long-term placement for a child or youth when resources cannot be secured. Such cases must be prioritized among the Authorities and the DFSH to find alternatives. These situations should be referred to a Multi-Disciplinary Treatment Team for case planning.

Recommendation:

- √ ***That the DFSH, along with the Four Authorities establish geographically-based multi disciplinary treatment teams to develop comprehensive care and treatment plans for high-needs children and youth. Membership on these teams must also include community members and line social workers from CFS agencies.***

3.6: Use of External Specialists

Children and youth in shelters have reported decreased school attendance once they are in shelter care. Shelter coordinators and staff have expressed frustration with administrative policy barriers that prevent children's immediate transfer to schools near shelters. Yet, educational professionals report lack of commitment by agency to child's educational needs, and the impact that changing placements and shelter care has upon a child's educational progress. Educational professionals indicate that there is a lack of understanding and communication between the agency and the education system.

Shelter staff working with children with specific medical care needs have raised similar concerns regarding lack of knowledge and communication with public health organizations that would assist in greater prevention and intervention for children and staff in the shelters.

Recommendations:

- √ ***The Agency, in conjunction with the DFSH develops the position of Educational Specialist to act as a liaison between the educational system and the emergency care program. The Educational Specialist should have a background in education and policy administration to assist with transitioning children in schools, to support children during this transition, and to assist with the development of educational planning and funding applications where necessary.***
- √ ***The Agency, in conjunction with the DFSH, develops the position of Health Specialist to act as liaison between the emergency care program and the public and mental health system. This position would be in addition to their current health care coordinator. The Health Specialist should have a background in public health in order to support to shelter staff in providing health intervention to children with specific medical care needs. The Health Specialist should also be responsible for the provision of ongoing training in health prevention for issues such as communicable diseases.***

SECTION FOUR: THE VOICE OF CHILDREN AND YOUTH

Of concern to the OCA is the lack of awareness of children and youth of the OCA. The OCA is an independent voice for children and youth inside our CFS system. They have a right to know of the office. They have a right to access the OCA. Their rights are not, however, guaranteed, as children and youth must rely on child and family services staff to inform them of the OCA.

> "A child's lack of power in the child welfare system can be balanced by the involvement of an advocate whose role is to ensure that the child's best interests and wishes are considered in the process".

Children and youth cannot fulfill their right to speak to the Children's Advocate if they are unaware of the existence of the OCA.

Recommendations:

- √ ***The DFSH ensure that all children and youth in care of a child and family service agency and who are able to understand are made aware of the OCA and that they can request a review of their circumstances through the OCA. This cannot occur on a one-time-only basis but requires a standard directing agencies to inform children and youth of the existence of the OCA.***
- √ ***The DFSH ensure that all child and family service agencies, residential care facilities, treatment centres, foster homes and emergency shelters are provided with rights information, as prepared and authorized by the OCA.***

Few youth were aware of the existence of Voices Manitoba Youth in Care, the youth-run advocacy group, mentored by the Winnipeg Boys and Girls Club. Youth can and do advocate for one another in an effective manner. Again youth are not able to access this resource if they are unaware of it.

Recommendations:

- √ ***The DFSH ensure that all youth (ages 14 to 18) in care of a child and family services agency are made aware of the existence of Voices Manitoba's Youth in Care.***
- √ ***The DFSH that all child and family service agencies and regional offices, foster homes, residential care and treatment centres and emergency shelters are provided information about Voices prepared and authorized by Voices Manitoba's Youth in Care.***

SECTION FIVE: THE FOSTER CARE SYSTEM

The EAPD system grew due to a resources crisis. The majority of children entered into the EAPD system from foster care. We have a crisis in foster care. As stated through the AJI-CWI process our foster care system will be reviewed. It is the sincere hope of the OCA that this process will begin to address the current issues. Again it was not the intention of the OCA to complete a foster care review but others in Manitoba, who have had the opportunity to review some aspects of our foster care system, have made recommendations to government. Most recently, Judge Linda Giesbrecht, in her report regarding the death of Patrick Redhead, recommended:

> "Rates paid to foster parents should reflect the value of the work that is being done. Barriers to recruiting foster parents in all parts of Manitoba need to be addressed. Foster parents need to be adequately supported. It is recommended that the Director of Family Services establish a committee including representatives from foster parents, the Office of the Children's Advocate and other stakeholder in the system to examine and address the following issues:
>
> - The payment fees to all foster parent based on the needs of the child and the ability of the foster parent to meet those needs;
> - The obstacles that exist in the system to recruitment of foster homes, in particular Aboriginal foster homes and foster homes in northern communities;
> - The need to provide appropriate supports to foster parents including respite and clinical support to meet the needs of the child;
> - The need to provide appropriate training to foster parents to enable them to meet the needs of the children in care."(2003: 209).

Recommendations:

√ ***That the DFSH and the Four Authorities implement the above noted recommendations of Judge Linda Giesbrecht.***

√ ***The DFSH and the Four Authorities work co-operatively with the Manitoba Foster Family Network to develop a province-wide strategy to address the recruitment, support and retention of foster families.***

√ ***The DFSH provide the Four Authorities with the financial support to develop one province-wide system to track foster home breakdown. This information will be of assistance to the Authorities to evaluate the needs of children and youth in foster care; evaluate the needs of foster care providers and assist in determining what barriers (case and systemic) contribute to the breakdown of foster care placements from a regional and provincial perspective. This information should be shared annually with the Manitoba Foster Family Network.***

√ ***That the DFSH support the endeavours of the Manitoba Foster Family Network to complete research determining what supports are needed to retain and support foster care resources. The results of their research should be shared among all Four Authorities.***

The development of emergency foster care for children be developed in conjunction with the Four Authorities and existing community agencies who already provide foster care programming to the CFS system. The DFSH will need to review its current foster care system utilizing the standardized classification system of the Community Resource Development Office (CRDO) to ensure consistency in the level of care provided, and that any emergency foster care system complies with Foster Care Regulations and Standards.

APPENDIX 1

THE METHOD OF THE SHELTER REVIEW

The methods used to carry out the review were:

- A Shelter Review Advisory Team (SRAT) was created to assist in the review. Membership of the SRAT included representation for the OCA (3); Voices Manitoba Youth In care (1); Private not for profit residential care program (1); and the DFSH (1) and WCFS (1). The purpose of the SRAT was to share information, receive input from the members of SRAT and to ensure the charter goals were being met.
- The OCA contracted Sangcorp Corporation to supervise all the staff and manager interviews to ensure fairness of the interview process. The OCA is keenly aware that the role of the OCA often puts OCA staff at odds with WCFS staff. To guard against a perception of bias in the interview process the consultants were charged to supervise the interviews to ensure consistency within the process.
- The OCA contracted with Dr. Alex Wright, Faculty of Social Work, University of Manitoba, to act as our consultant to the review. Dr. Wright reviewed all interview tools used with shelter staff, coordinators, social workers and children and youth. Dr. Wright also assisted in the analysis of the statistical data provided by WCFS as it pertained to the population of children and youth residing in the shelter system.
- The OCA conducted a series of pre interviews with key personal (21) inside WCFS (Resources in Support of Services and Services to Children and Families program areas) and the DFSH to obtain historical information of evolution of EAPD, program goals, objectives, definitions and process and licensing regulations.
- The OCA met with major stakeholders (agency, union and government) periodically to inform them of the purpose and progress of the review.
- The OCA interviewed 38 or 30% of the children and youth that had been placed or were placed in the shelters on a randomly selected day. These interviews were conducted with a standard interview tool. Their (children and youth) confidentiality and anonymity was guaranteed.
- The OCA interviewed 25 shelter staff. Twenty-two (22) were WCFS shelter staff employed in the shelter system. Only 2 staff among the 25 identified as purchased service staff. These interviews were conducted using a standard interview tool. Interviews were voluntary. Shelter Staff, both WCFS permanent and casual staff and purchased services staff, were sent a standard letter from the OCA requesting that they contact the OCA if they wished to be interviewed. These interviews were confidential and staff anonymity guaranteed.
- The OCA interviewed one EAPD Dispatcher and a current staff person (1) assigned to conduct training in the Resource Program. Confidentiality and staff anonymity was guaranteed.
- The OCA interviewed 11 shelter coordinators. All interviews were voluntary and confidential. The coordinators participated first in a focus group and followed up with in person interviews.

- The OCA conducted one focus group for WCFS social workers and supervisors. The group comprised 6 social workers/supervisors representing direct Service to Child and Families units in both rural and urban areas who place children at the shelters. In addition we allowed for those who could not attended to provide written feedback to the OCA about their experiences in placing children at the shelters. Staff involvement was voluntary and confidentiality and anonymity was guaranteed.
- The OCA interviewed current executive managers (5) of WCFS who hold administrative responsibility for the shelter system. These interviews included Project Manager (Resources in Support of Services); Program Manager (Resources in Support of Services); Director of Human Resources; Chief Financial Officer and Chief Executive Officer.
- The OCA Interviewed CUPE union officials (2) the current president of CUPE and the Chair of the Health and Safety Committee. The OCA also reviewed documentation provided by CUPE as well as the CUPE, April 2003 report entitled *Investigation into the Shelter and In-home Support Systems of the Winnipeg Child and Family Services Agency.*
- The OCA interviewed 3 individuals who held management positions in WCFS during the WCFS reorganization plan that took place in 1999. These individuals were guaranteed anonymity and confidentiality and their participation was voluntary.
- The OCA interviewed the 4 DFSH staff persons holding the positions of Director Managed Care; Provincial Investigator, Training Coordinator and Licensing Coordinator who were deemed by the OCA as having direct knowledge and employment duties as related to residential care.
- The OCA reviewed past and current (1997 to 2003) CFS legislation, regulation, policies and procedures as they related to the emergency care of children and youth in the CFS system in Manitoba.
- The OCA conducted on site inspections of 47 shelters as well as conducting an EADP file audit as related to shelter (licensing application, variances granted, staff configurations assigned to shelter and shelter administrative files inclusive of child and staff communication logs). The OCA also observed a licensing review of a shelter conducted by the DFSH staff.
- The OCA reviewed all provided documentation with respect to the EAPD program including WCFS Board minutes (1997 to 2003), EAPD program policies and procedures, CUPE Collective Agreements; applicable job description and internal documents and reports inclusive of financial reports related to the EAPD program from 1997 to 2003.
- The OCA interviewed and or requested information from collateral agencies representing, foster parents, residential care programs, child mental health, education and policing.
- The OCA completed literature reviews (provincial, national and international) regarding state funded, provided and regulated child welfare services; specifically focussing out-of-home care (emergency, foster, group and residential care); case planning for children in care; access to children in care, reunification and reentry into care; demographic characteristics of children in care (age, gender and ethnicity). We completed literature reviews on staff competencies and the use of Intrusive Measures with children and youth in residential care in Manitoba and Ontario. We completed a literature review on youth participation in decision making in social service systems.

- The OCA reviewed other provincial reviews of residential care setting (child welfare and youth criminal justice) in Ontario, Nova Scotia and Saskatchewan.
- In summary the OCA, in completing of this review, interviewed 124 children, youth, staff, managers and collaterals that had direct knowledge of and experience in WCFS-EAPD program. The OCA reviewed the statistical data provided by WCFS of 3085 children and youth placed in the EADP program between 1997 to 2003. The OCA conducted on site inspections of the 47 shelters actively operating as of June 2003. The OCA reviewed all material made available with respect to the EAPD system and completed a file audit on all EAPD administrative files.

APPENDIX 2

A National and Provincial Overview

In Canada:

As reported by the Child Welfare League of Canada (CWLC)[1] in 2003:

- Currently there are approximately 76,000 children and youth in care across Canada.
- Over the last decade the number of children and youth who require protection services and out of home care has increased significantly.
- But the number of available family-based care homes (adoptive, foster, kinship, customary and guardianship care) has significantly decreased.
- Compounding the increased demand and the decrease in family-based care settings, the length of time a child or youth remains in foster care has increased.
- U.S. literature reports an increase of 58 per cent since 1990 in the number of children and youth being placed in group care (non family-based care typically care provided by staff in a home or facility usually housing six to nine residents).
- The CWLC believes that the increased number of children and youth placed in group care implies a shortage of family based settings, "and thus many vulnerable children are inappropriately placed in group-care."
- As reported by the CWLC approximately 30 to 40 per cent of children and youth in care across Canada are aboriginals.
- In Western provinces the number of aboriginal children and youth in care rises significantly to 68 per cent.
- Correspondingly there is an increased workload for child welfare workers. As cited by the CWLC:

  > "Increased responsibilities for workers, without proportionate staffing support, can be attributed to the dramatic increase in the number of child welfare investigations (CECW, 2003)."

In Manitoba:

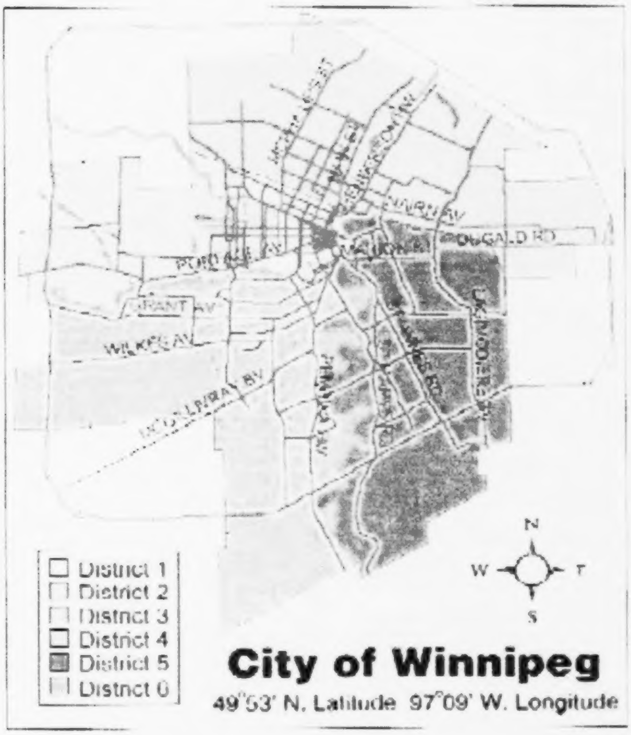
- In Manitoba, as of March 31, 2003, there were 5,533 children and youth in care.[2]
- Eighty-one per cent of those children and youth were aboriginal children and youth.[3] Yet aboriginal children and youth (under 15) account for only 21per cent of Manitoba population.
- In 2002 to 2003 there were 2,525 children and youth in care of WCFS (46 per cent of the total number in care in Manitoba).
- Of the 2,525 children and youth in care of WCFS, 69 per cent are aboriginal children and youth.
- In Manitoba (2003) there were 43 residential care facilities operated by four child care treatment centers and 12 organizations and agencies providing 266 residential care beds.[4]

- As of March 31, 2003 in Manitoba, 333 children and youth were in residential care (private group homes, own agency group homes, residential treatment centers). An additional 967 children and youth were in other group placement resources (St. Amant Centre, Manitoba Youth Centre, hospitals and other facilities). This means that 1,300 children and youth or 23 per cent of the total number of children and youth in care were placed in group care as opposed to family-based settings.[5]
- As reported by WCFS (2002 annual report) 72 per cent of the children and youth in their care were living in family-based settings. According to the Department of Family Services and Housing 2002-2003 Annual Report 25 per cent of the children and youth in WCFS care were in group care.
- It is apparent that the caseloads of child welfare workers in both First Nations and Non First Nations agencies throughout Manitoba has been alarmingly high. As reported by the Awasis Agency of Northern Manitoba during the Patrick Redhead Inquest in the 1990s a child welfare worker in Shamattawa could have been carrying a caseload as high as 80 to 90 cases. As reported by Voices Manitoba Youth in Care (video: Moving In, Moving On, Moving Out) WCFS social workers can carry as many as 50 cases.

APPENDIX 3

Winnipeg Police Services

District Boundaries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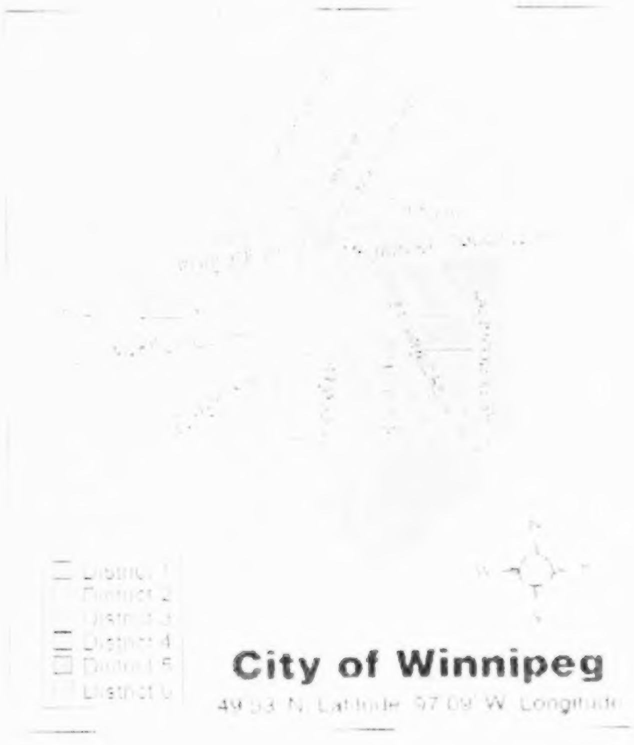
APPENDIX 3

Winnipeg Police Services

District Boundaries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APPENDIX 4

FOSTER CARE RATE 1997-1998

CHART OF ACCOUNTS	**South of 53°**		**North of 53°**	
	0 - 10	**11 - 17**	**0 - 10**	**11 - 17**
Household Allowance	.43	.43	.45	.45
Bedding and Linen	.44	.44	.46	.46
Repairs and Equipment	.86	.96	.90	1.01
Utilities	1.02	1.02	1.07	1.07
Food	5.30	6.74	5.56	7.08
Health and Personal Care	.50	.78	.53	.82
Transportation	1.50	1.50	1.57	1.57
Respite	1.74	1.74	1.83	1.83
Replacement Clothing	1.76	2.20	1.85	2.31
Personal Allowance	.64	1.47	.67	1.54
Babysitting/Child Care	1.14	1.14	1.20	1.20
Damages/Deductibles	.90	1.73	.95	1.81
TOTAL TO FOSTER PARENT	16.23	20.15	17.04	21.15
AGENCY ALLOWANCE GIFTS	.26	.26	.27	.27
Activities, Education, Special Occasion, and Other Special Costs	1.07	1.07	1.12	1.12
SUB-TOTAL	1.33	1.33	1.39	1.39
TOTAL RATE	17.56	21.48	18.43	22.54

APPENDIX 4

FOSTER CARE RATE 2003/2004

Effective July 1, 2003

PAYABLE TO FOSTER PARENTS					**North of 53 East of Lake Wpg. N51 12' (no road access)**	
CHART OF ACCOUNTS	**SOUTH OF 53°**		**NORTH OF 53° (road access)**			
	0 – 10	**11 – 17**	**0 – 10**	**11 – 17**	**0 – 10**	**11 - 17**
Household Allowance	.45	.45	.47	.47	.47	.47
Bedding and Linen	.46	.46	.48	.48	.48	.48
Repairs and Equipment	.90	1.00	.94	1.06	.94	1.06
Utilities	1.07	1.07	1.12	1.12	1.12	1.12
Food	5.55	7.04	6.10	7.75	8.03	10.21
Health and Personal Care	.52	.82	.55	.86	.55	.86
Transportation	1.57	1.57	1.64	1.64	1.64	1.64
Respite	1.81	1.81	1.92	1.92	1.92	1.92
Replacement Clothing	1.85	2.30	1.94	2.42	1.94	2.42
Personal Allowance	.67	1.54	.70	1.61	.70	1.61
Babysitting/Child Care	1.19	1.19	1.25	1.25	1.25	1.25
Damages/Deductibles	.92	1.81	.99	1.87	.99	1.87
TOTAL TO FOSTER PARENT	**16.96**	**21.06**	**18.10**	**22.45**	**20.03**	**24.91**
AGENCY ALLOWANCE Gifts	.28	.28	.29	.29	.29	.29
Activities, Education, Special Occasion, and Other Special Costs	1.12	1.12	1.17	1.17	1.17	1.17
SUB-TOTAL	1.40	1.40	1.46	1.46	1.46	1.46
***TOTAL RATE**	**18.36**	**22.46**	**19.56**	**23.91**	**21.49**	**26.37**
Northern Food Allowance			.28	.34	2.21	2.80

*Includes Northern Food Allowance

Endnotes- Part 3

[1] Each geographical area contained a four-bed unit for short-term emergency care. The model within WCFS-southwest is not included in this discussion as the model was administered as licensed foster care under provincial regulations, for placements of short term care provided in the care-providers' own homes. This model provided more autonomy for the foster parents as they were given a set per diem rate and facilitated their own respite.

[2] Prairie Research Associates was commissioned by the Department of Family Services in 1997 to conduct an operational review of WCFS. The intent was to trace reasons for cost escalation. This was to be achieved by focusing on an assessment of the organizational structure, service delivery, and resource allocation in an environmental context that identifies systemic and policy factors in the increases of service demands. It also provided a comprehensive analysis of agency programs and financial models, and a review of the relationship between WCFS and external agencies.

[3] Prairie Research Report reveals that in the summer of 1996, 78 children were lodged in hotels with 24-hour shift staff from the agency casual staff, or from staff supplied by external contract.

[4] EAPD mission and vision statement indicates the provision of functional assessments. These have been defined by EAPD coordinators and supervisors as day to day observation of child's activities of daily living, the child's emotional, social and behavioral issues and the identification of successful interventions in responding to the observed behaviors. The assessment of the resources required to match the needs of the child. These assessments would be used in identifying future long term or treatment placement resources that matched the child to the appropriate resource.

[5] These do not include the specialized four bed units for adolescent parents which tend to have longer term length of stay due to the focus of mentoring and support.

[6] The southwest and east areas of the agency continued to rely upon a similar four bed model of receiving where services were provided in the foster parent's own home.

[7] This information is qualitative and anecdotal. The information was furnished by a variety of WCFS employees employed within the EAPD program within the last seven years. Respondents to questionnaires, surveys and personal interviews were asked to respond to how EAPD was developed, and how does/did it fit into the agency's foster care system. There was no quantitative evidence found that demonstrates this success.

[8] Information obtained through series of personal interviews with a variety of WCFS management and Executive Management personnel and through a focus group conducted with EAPD coordinators.

[9] Information obtained through series of personal interviews with a variety of WCFS management and Executive Management personnel.

[10] Information obtained through the Department of Family Services Residential Care Licensing Branch

[11] Information obtained through personal interviews with Agency management personnel, and Department of Family Services and Housing personnel.

[12] *The Child and Family Services Act*, (1999) Manitoba Standards and Regulations p.252.

[13] The Manitoba Standards and Regulations for Child Care facilities outline the application for license to include: a written proposal of program goals, the residents to be served in the facility, the services provided by facility to residents, documentation for need of facility, description of client population needs to be served, qualifications and training of applicant, and the necessary child abuse and police registry checks.

[14] Interview with Department of Family Services and Housing Personnel.

[15] Staffing qualifications are to minimally include: CPR, First Aid, Appropriate record checks, reading writing and comprehension skills, and an adult who is mentally, emotionally, physically able to do work. There are no minimum educational requirements, and further qualifications and competencies can be determined by each child care facility. Child Care Facilities Licensing Manual (1999) Requirements and Standards. p. 22.

[16] Guidelines are identified as, but not exclusive to: assisting residents in activities of daily living, monitoring or assisting with medical needs, general supervision and guidance, maintenance of fire safety and public health standards, maintenance of required records, consulting with supervising agency and Licensing Authority, provision of social/recreational opportunities, dietary food service, and general housekeeping. Child Care Facilities Licensing Manual (1999) Requirements and Standards. p. 25.

[17] Common Characteristics of residential treatment services: flexible to individual need, child-centred, family focused and culturally responsive, promote empowerment, emphasize assessment and identification of strengths, and recognize reunification as a significant event. Child Care Facilities Licensing Manual (1999) Requirements and Standards. p. 32.

[18] Reported in Personal interview with staff from DFSH.

[19] Reported in personal interviews with DFSH staff, and in interviews with WCFS staff

[20] WCFS manager interview.

[21] WCFS Shelter Coordinator's interviews.

[22] Program Statement indicates that facilities must have the following characteristics: flexible to the needs of child, child-centred, family focuses, culturally responsive, empowering, encouraging, and advocacy. The statement also indicates that facilities need to provide strength based assessments, recognize reunification as important, will provide

advice, teaching and support to parents, will connect child/family to community in support of reunification, and invite parents to the facility and encourage parents to actively participate in a child's life. Child Care Facilities Licensing Manual (1999) Requirements and Standards. p. 47.

[21] Child Welfare League of America (1991) Standards of Excellence for Residential Group Care Services, pp. 98-103.

Endnotes – Part 4

[1] The CIS was conducted in 1998, surveying 51 sites inclusive of three aboriginal agencies across Canada. Though the sample size is large the results cannot determine frequency rates of child maltreatment in Manitoba. The CIS does not include cases investigated only by police, cases known to other professionals and or the larger community but not reported to child welfare authorities, and unknown cases.

[2] For definitions please see (I) *Canadian Incidence Study of reported Child Abuse and Neglect (2001).*

[3] McKenzie, B & Trocme, N (2003) *Child Maltreatment: Themes and Implications.*, cited in Kufeldt, K & McKenzie, B., ***Child Welfare. Connecting Research, Policy, and Practice***. Wilfrid Laurier University Press, Ontario Canada. 67-77.

[4] MacLaurin, B et al (2003) *Characteristics of Investigating Children and Families Referred for Out-of-Home Placements*, cited in Kufeldt, K & McKenzie, B., ***Child Welfare. Connecting Research, Policy, and Practice.***, Wilfrid Laurier University Press., Ontario, Canada., 27-41

[5] Ibid

[6] Ibid

[7] Ibid

[8] MacDonald, RAJ & Ladd, P (2000) First Nations Child and Family Services. Joint Policy Review. Draft Final Report. AFN, Ottawa Canada.

[9] Cameron, G (2003) Promoting Positive Child and Family Welfare, cited in Kufeldt, K % McKenzie B (eds), ***Child Welfare. Connecting Research, Policy, and Practice***. Wilfrid Laurier University Press, Ottawa Canada. p. 83

[10] Ibid, pp 79-99

[11] Ibid

[12] Sparrow Lake Alliance (1996)., ***Children in Limbo***., Canada, p. 12

[13] McKenzie, B & Trocme, n (2003) p.70

[14] Ibid

[15] K. Kufeldt, et al (2000), ***Looking After Children in Canada Final Report***. HRDC, Ottawa Canada., p. 214

[16] Farris-Manning, C. & Zandstra, M (2003) ***Children in Care in Canada***., CWLC, Ottawa Canada., p. 3

[17] Children with special needs are defined as children who require additional resources (public or private) beyond those normally required to support his/her healthy development. (UNESCO).

[18] Farris-Manning, C. & Zandstra, M. (2003), p. 9

[19] Ibid

[20] Cameron, G (2003) p. 81

[21] WCFS STEP database was only in existence for three months at the time of the review. The STEP database could not be used for this review, as we wanted to collect trend data.

[22] Mean 43.9706; Median 24.0000; Mode 1.0.

[23] Mean 41.3143; Median, 22.0000; Mode 1.00.

[24] These shift staffed foster homes were likely shelters not licensed as residential child care facilities. The agency prior to 1999 did not license shelters and considered many as quasi-foster homes.

[25] Order of Supervision is not considered an appropriate legal status for a child placed in care, it is likely that these children were removed from a familial setting, while under an Order of Supervision and brought to the shelters without the appropriate re-designation of legal status. WOA are children placed under the care of another CFS agency beyond WCFS. Their guardian agency and not WCFS record these children's legal status.

[26] The inspection guide was premised upon concepts of the California Children's Bureau family assessments. The purpose of the guide was to assess the shelters based upon provincial standards and program statement requirements of standards in residential care, as well as the Child Welfare League of America's international standards of residential care. Anecdotal reports from WCFS staff regarding what ideally should be included in the physical shelter. The OCA sought advice and recommendation from the licensing branch of DFSH regarding licensing and relevant information to be considered. The Shelter Review Team, prior to its implementation approved this assessment format. The intent of the guide was to provide a standardized assessment format for each shelter. The shelters were rated on a 3-point scale from ideal conditions for a shelter (1) to least desirable condition (3).

[27] At the onset of EAPD the establishment shelters followed criteria that indicated the shelter needed to be in close proximity to schools, daycare, parks and other community resources, and access to public transportation. Further, they also needed to be in neighbourhoods that were identified as the neighbourhood location where most children entering into care, reside. The goal was to maintain a child to the community. EAPD senior managers, coordinators, and WCFS Executive Management reported this information to the OCA.

[28] Concerns regarding lack of matching of child to resource were expressed to OCA by shelter staff, coordinators, placement desk and social workers. It was consistently reported that the focus within the last 2 years has been to fill the open bed spaces.

[29] This decision was made, as we were concerned about adequately designing an interview process that would have elicited information from the younger child. However, first and foremost we were concerned about the possible stress an interview may have on the very young child. We were also lead to believe that the majority of children and youth inside the shelters were the older child and the adolescent youth. This decision not to interview the younger child was made prior to the OCA completing the statistical analysis of children and youth placed over five years, and as a result we were unaware of the high numbers of younger children ages 0 to 6 placed in the shelters. We realize that there are those who will criticize this decision, but in hindsight we still would not have interviewed the younger child due to our same concerns about the impact of such a process on the individual child.

[30] The OCA interview 10% of the staff group. We encounter difficulties, as we could not gain information about the exact number of staff, permanent or casual and the number of purchased service staff used. We were informed that WCFS employed 193 permanent staff, 28 were on leave. Casual staff numbered 59. Total staff group 252. Total staff group available to be interviewed 224. Twenty–five interviews exceeded our requirement of 10% of the total staffing group.

[31] Federal-provincial Working Group on Child and Family Services Information., September 1999.

[32] Foster home count does not include Place of Safety Homes or foster homes that WCFS licensed for external agencies.

[33] Manitoba Family Services Annual Report, 1995-1996, p.79.

[34] Manitoba Family Services and Housing Annual Report 2002-2003, p. 95.

[35] WCFS Internal Placement Desk monthly statistical report.

[36] AJI-CWI: Summary of the DIP for Restructuring the Child and Family Services System in Manitoba (2003), p.2.

[37] Ibid.

[38] The reasons for a shortage of foster care resources across Canada is taken from Farris-Manning & Zanstra (2003) ***Children in Care in Canada***. Child Welfare League of Canada, and augmented by the OCA.

[39] Strijker et al (2002) pointed out that an unsuccessful placement might trigger 'burnout' in a foster parent and result in the loss of a qualitatively good foster home. The Saskatchewan's Children's Advocate, Dr. D. Parker-Lowen in her April 2000, report ***Children and Youth in Care Review: Listen to their Voices*** found "when homes are overloaded, children and foster homes mismatched, workers rushed for time and foster parents under supported and underpaid, safety concerns arise" (p.62).

[40] WCFS staff interviews.

[41] Children's Advocate, J. Mirwaldt in her testimony at the Patrick Redhead Inquest (See: The Fatality Inquires Act Report by Provincial Judge on Inquest Respecting the Death of : Patrick Redhead.(January 16, 2003).

[42] Source; Manitoba Family Services and Housing Charter of Accounts 1997-1998 and Charter of Accounts 2003-2004 (effective July 1, 2003).

Endnotes- Part 5

[1] WCFS staff interview

[2] EAPD Program Home Manual

[3] WCFS Shelter Coordinator interview

Endnotes - Part 6

[1] Also known in the system as the Director of the Child Protection and Support Branch

[2] As outlined in the EAPD Home Manual

[3] WCFS staff interviews

[4] All IR filed by WCFS to the DFSH 2001 to 2003

[5] WCFS staff interviews

[6] WCFS manager interview

[7] WCFS managers interview

[8] WCFS managers report that the DFSH has requested not to be provided IR relating to youth AWOL. Current licensing standards do not require AWOLS to be reported to the DFSH. WCFS internal policies require all AWOLs to be reported to the agency, the child's worker and the police.

[9] Garrison, W. et al (1990) *Aggression and Counter Aggression during Child Psychiatric Hospitalization*. Journal of American Academy of Child and Adolescent Psychiatry, 29:2, March 1990. 242-249

[10] The breakdown of PAI reports (number of alleged child victims and number of staff investigated) per year is a follows; year 2000, five children and five staff; year 2001, 12 children and nine staff; year 2002, 13 children and 11 staff; January 2003, seven children and three staff.

[11] The OCA, in reviewing the PAI reports used the definitions of Substantiated, Suspected and Unsubstantiated from the *Canadian Incidence Study of Reported Child Abuse and Neglect (2001)*. Substantiated: "The balance of evidence indicates abuse or neglect has occurred. Suspected: "There is not enough evidence to substantiate maltreatment, but there nevertheless remains a suspicion that maltreatment has occurred". Unsubstantiated: "There is sufficient evidence to conclude that the child has not been maltreated".

[12] Shelter staff were asked to describe their child management techniques when dealing with violent or aggressive children and youth. Staff were asked to describe their techniques and were not offered multiple-choice answers; shelter staff could describe any and all techniques used. The OCA then calculated the number responses and categorized into type according to the answers provided. Categories used were Time Out/Isolation; verbal re-direct; Loss of Privileges; restraints; Calling for Assistance; Other.

[13] WCFS Manager interview

[14] The Province of Ontario (1997) Office of the Child and Family Service Advocacy. Guidelines for Intrusive Procedures. p. 3

[15] OCA reviewed the policies with respect to the use of Intrusive Measures used in Knowles, Marymound and New Direction for Youth.

[16] WCFS (September 21 1999), Memorandum to EAPD Staff and Professional Foster Parents. Protocol For Accessing Assistance in Dealing with Children Who Are Out of Control.

[17] WCFS Home Manual. Behavioural Response Manual. February 28, 2001.p. 4

[18] CFS contact could include other than WCFS CFS agency related/initiated calls.

[19] Group Care is defined as private group home, own-agency group home and residential care centres

[20] DFSH 2002 to 2003 Annual Report

[21] Reported request by Shelter staff to YECSS staff.

[22] WCFS EAPD (March 23, 1998) Committee on Internal Crisis Intervention/ Stabilization Services.

[23] WCFS management staff interviews

[24] British Columbia Office for Children and Youth. (2002). Report on The Educational Attainment of Children in Care in British Columbia. P.23

[25] Kufeldt, K., J. Vachon, M. Simard (2000). Looking after Children in Canada: Final Report . Human Resource Development of Canada.

[26] Interviews with school personnel of Winnipeg 1 School Division, June 16, 2003, July 14, 2003.

[27] Kufeldt, K., J. Vachon, M. Simard (2000). Looking after Children in Canada: Final Report. Human Resource Development of Canada. P.27

[28] Kufeldt, K., J. Vachon, M. Simard (2000). Looking after Children in Canada: Final Report. Human Resource Development of Canada. P.30.

Endnotes Part 7

[1] WCFS provided only the requested breakdown for years 2000 to 2003. The OCA was informed that the agency's practice was to archive financial information not required, as a result the years requested, 1998 to 2000 were not made available to the OCA.

[2] Agency reported that in April 2002 the salary range of a 24-hour staff was $39,239-$54,236. For a 12-hour shift staff the salary range was reported as $25,769-$36,910.

[3] WCFS staff interviews

[4] Manitoba Finance Internal Audit Report on Family Services & Housing WCFS. Shelter System Financial Practices & Procedures. September 2003

[5] Ibid, p. 1

[6] Ibid p. 3

[7] WCFS staff interviews

[8] WCFS staff

[10] The term management in this section describes positions from coordinators to Board, unless otherwise indicated, and senior manager describes positions from supervisors to Board.

[10] WCFS staff interviews

[11] WCFS staff interview

[12] WCFS staff interviews

[13] WCFS staff interview

[14] WCFS staff interviews,

[15] WCFS memo, October 17, 2000 to the Board. Update on Collective Bargaining.

[16] Collective Agreement between CUPE Local 2153 (Support Workers and WCFS. Terms of Agreement April 1, 2000 to March 31, 2003. Article 15.04.

[17] For further explanation please see Article 15.04 of the Collective Agreement (April 2000 to March 2003).

[18] WCFS memo, October 17, 2000 to the Board. Update on Collective Bargaining.

[19] WCFS staff interview

[20] This was clearly evident in all OCA interviews with CUPE officials and WCFS management staff both past and present.

[21] WCFS staff interview

[22] Source: WCFS Human Resource Department

[23] All child out of family placements (EAPD to foster care to residential care), Family Support Services, Independent Living, Transportation and Preventative Health Care. In 1998 an internal agency memo to agency staff (October 6, 1998) the program also was reported to include Family preservation/reunification, family therapy/mediation services, Sexual Abuse Treatment and FAS/FAE services.

[24] WCFS executive manager interview

[25] WCFS staff interview

[26] Shelter Review Report completed.

[27] WCFS Interim Management Board Meeting Minutes of March 5, 2002.

[28] Ibid

[29] WCFS-Child Protection and Support Service Branch. Joint Planning Committee. Short-term Resources for Children. Terms of Reference. March 2002. P.2.

[30] WCFS November 22, 2002 Issue Document.

[31] WCFS Issue note, May 21, 2002

[32] In a May 21, 2002 WCFS Issue note, the agency stated that Employment Standards legislation concerning termination of employees does not apply to the shelter strategy given that it is to be implemented over 13 months and is impacting on a group of fewer than 50 employees in a four week period. The agency was committed to assist CUPE workers affected by the strategy through redeployment as family support workers of opportunities with other employees such as Home Care. MGEU, band four shelter coordinators positions would become redundant and as many as 7 coordinators would be laid off.

[33] See end note 24

[34] WCFS Labour/Relations Activity report to the OCA (October 10, 2003)

[35] CUPE (2003) Investigation into the Shelter and In-home Support Systems of WCFS., p. 12.

[36] WCFS shelter coordinators interview, WCFS management interviews.

[37] Anderson, M & Gobeil, S (2002), Recruitment and Retention in Child Welfare Services: A Survey of Child Welfare League of Canada member Agencies. Centre of Excellence for Child Welfare, Ottawa Canada. P. 4

Endnotes - Part 9

[1] The Center for the Study of Social Policy (1991)

[2] Ibid

[3] WCFS EAPD Home Manual

Endnotes - Appendix 2

[1] Farris-Manning, C. & Zandstra, M. (2003), ***Children in Care in Canada: A Summary of Current Issues and Trends with Recommendations for Future Research.*** CWLC., Ottawa Canada

[2] Manitoba Family Services and Housing, Annual Report 2002-2003.

[3] Ibid

[4] Ibid

[5] Ibid

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